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Between Ourselves

Reports in the press and popular magazines regarding new scientific developments and practices frequently overstress the value of the treatment that is being offered. False hopes are raised in the hearts of sufferers from this or that disease. There is a flutter of excitement over the possibilities of miraculous cures. Then cold water is dashed on the proposition and the public's attention is diverted to some other drug or invention or procedure.

Nurses everywhere are badgered by patients and their families for personal opinions on the value of these new methods as they are reported. Being canny individuals, for the most part, the nurses are careful and guarded in their comments until they have some direct information through this or other professional periodical regarding the development in question. We are especially pleased, therefore, to be able to provide such an authoritative article on ***High Energy Radiation Therapy Using Cobalt 60*** by **Dr. H. E. Johns.** This highly informative and authentic information was presented by Dr. Johns to the nurses of Saskatchewan at their annual convention this year.

* * *

Those persons who, unhappily, are subject to ***migraine headaches*** will rejoice that the treatment, described by **Dr. A. S. Barnum,** as being the vogue in the middle ages has now been superseded by gentler methods. Since the etiology of this distressing condition is still unknown the fact that less severe treatment is available than applying a hot iron to the head may be some consolation.

* * *

The article, dealing with the symptomatic management of the ***allergic patient*** by **Dr. C. H. A. Walton** is the last of the series on the whole broad field of allergy that we have been carrying since last July. We are most grateful to him and to Dr. J. H. MacDermot, editor of *The Bulletin of the Vancouver Medical Association,* for having given us the opportunity to present this complete picture to you.

* * *

You will chortle over the true-to-life pen sketches that illustrate **Lucy Willis'** account of her experiences as educational and social director in a large school of nursing. Miss Willis was in charge of the program for its first three years. She has given us only a brief glimpse of the changes that took place in the arrangement of social and personal interests. For those who are concerned with how a ***student adviser program*** may be introduced into a hospital school of nursing there is much food for thought. The rest will enjoy simply reading of her experiences. Miss Willis is a graduate of Toronto Western Hospital. She secured her university education in Vancouver and New York.

* * *

Stemming from a symposium on ***nutrition*** presented at the recent convention of the Canadian Public Health Association, "What Should Tommy Eat" is being published simultaneously in our *Journal* and in the *Canadian Journal of Public Health.*

* * *

Several people have asked why we have been putting out *Journals* with fewer pages these past couple of issues Actually, both the September and October numbers were eight pages over our standard 80-page issue. Still, those issues feel thinner! The explanation is that, in the interests of economy in production, we switched from the squarish side-binding to ***saddle-binding.*** We hope you will get used to it and like it as well.

* * *

Christmas *is almost here again.* Perhaps you will have noticed that we have not included the ***special subscription blanks*** in the end-of-the-year issues as formerly. This, too, is in the interests of economy in operation. Nonetheless, we have special gift cards on hand to mail at your direction to any of your friends for whom you wish to send the gift of a subscription to this *Journal.* Get your order in right away to avoid disappointment.

* * *

Christmas! God grant that we may all experience the lovely side of Christmas in our homes and with our families and friends.

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Manufacturer — Bristol Laboratories of Canada Ltd., Montreal.

Description — New formula, per fl. oz.: Ferric ammonium, citrate green 668 mg., riboflavin 4 mg., thiamin HCl 10 mg., niacinamide 100 mg., liver fraction 1, N.F. 1 gm., vitamin B_{12} 1 mcg.

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Administration — Adults—one tablespoonful 3 times daily during or immediately following meals. Children—6 to 12 years, 2 teaspoonfuls 3 times daily; 1 to 6 years, 1 teaspoonful 3 times daily.

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Manufacturer — Parke, Davis & Co. Limited, Walkerville, Ont.

Description — Cream containing 1% Benadryl HCl with Calamine.

Indications — Itching and pain due to hives, sunburn, poison ivy or oak, insect bites, etc.

TYOTOCIN Ear Drops

Manufacturer — Sharp & Dohme (Canada) Ltd., Toronto, Ont.

Description — Tyrothricin 0.05%, benzocaine 1.25%, antipyrine 5.0%, hexylresorcinol 0.1%, propylene glycol anhydrous 50%, glycerin anhydrous q.s. to 100%.

Indications — For treatment of bacterial and mycotic infections of the external ear; for adjunctive treatment of acute otitis media when eardrum is intact.

Administration — By direct instillation into the ear canal or by packing the canal with a gauze wick saturated with the solution. Repeated as prescribed.

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Indications — Anticholinergic agent. Indicated in initial control of peptic ulcer and other acute conditions associated with hypermotility or hyperacidity of the stomach.

Administration — According to body weight — 0.5 mg./kg. 4 times daily.

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Manufacturer — Sharp & Dohme (Canada) Ltd., Toronto, Ont.

Description — Brand of metaraminol bitartrate, intranasal decongestant, in 0.25% isotonic solution.

Indications — In the relief of coryza, rhinitis, sinusitis, and nasopharyngitis. Its effective yet gentle decongestive action in the inflamed and engorged mucosa promotes drainage and permits easier and more normal breathing. Because of its gentle action and pleasant flavor, aramine solution is readily acceptable to both adults and children.

Administration — Employing the ('Mijit') atomizer, the solution may be used as a spray, or it may be administered by the dropper method. The recommended dose is one or two sprays in each nostril or, if the dropper method is preferred, two or three drops instilled into each nostril. May also be applied to packs and tampons for intranasal use.

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Manufacturer — A. Wander Limited, Peterborough, Ont.

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➧ Vitamin B_{12}	30 mcg
Folic Acid	3.6 mg.
Stomach-Liver Digest	1.5 Gm.
Thiamine Mononitrate (6 times MDR*)	6 mg.
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Nicotinamide (2 times RDA†)	30 mg.
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid	6 mg.
Ascorbic Acid (5 times MDR*)	150 mg.

*MDR–Minimum Daily Requirement
†RDA–Recommended Daily Dietary Allowance

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MONTREAL, DECEMBER, 1952

The Power of Words

"There is a weird power in a spoken word . . . and a word carries far—very far—deals destruction through time as bullets go flying through space."

These words of Joseph Conrad are of particular significance in these days when communication is so rapid and takes so many forms. Everywhere people are being affected, either happily or unhappily by words—spoken or written by someone else. Some words, of course, have little or no significance for us, because the people who speak them mean little to us, but there are other people whose every sentence takes on vivid meaning. In your own experience, have there not been times when you have waited tensely expectant for the next words of someone speaking to you? And then have you often felt bewildered and at sea because you failed to understand their exact meaning?

Do we ever stop to think that, as nurses, all our words are invested with particular meaning by our patients? These words can promote either healing or its opposite, depending not only on the actual words used, but the way they are said, and the meaning they are given when heard. If we can take time to enlist the patient's cooperation by a simple explanation before initiating a new treatment; forestall unnecessary fear by reassurance and understanding; and create a feeling of confidence by our own genuine concern for the patient's peace of mind—then, indeed, we will be hastening the healing process in a very definite way.

On the other hand, there are many occasions when we withhold, usually for little or no reason, words which might equally well help the patient toward recovery. The cheerful greeting that remains unuttered because of preoccupation or the message from a relative which never reaches the bedside because of forgetfulness—these are but examples of destructive factors which, in some cases, might actually retard recovery.

There can be no real healing of physical ills while the mind is in distress and our method of communication is one of the ways in which every nurse can promote a mind at ease. If we remember that everything we say is interpreted by the patient in the light of her own feelings and knowledge, not necessarily by the actual meaning of the words themselves, then we realize the power that is ours and use it carefully and with kindliness.

Though the world of today seems filled with thoughts and words that "deal destruction through time," we have at this season a sure antidote in the thoughts and words that are in all hearts—"Peace on earth to men of goodwill."—C.W.P.

A Merry Christmas to You All

Studying the Structure Study

Six months have elapsed since the Report, prepared by Dr. Pauline Jewett under the direction of the Structure Study Committee of the Canadian Nurses' Association, was presented to the convention body in Quebec City. It will be recalled that the disposition of the Report at that time was that it should go to the membership, for study and consideration during the ensuing biennium, and be brought forward for possible decisions at the convention in 1954. One quarter of the biennium has now passed. How much time, thought, and discussion have local nurses' associations and individual nurses given to it?

Reports that have reached the *Journal* offices from various parts of Canada have indicated, largely, a sense of bafflement concerning the proposed program of study. Nurses have stated that, though they have read the Report with a considerable degree of care, they are "in the dark" about the changes that have been proposed. A frequent comment is "What next? Where do we go from here?" In an endeavor to whet the curiosity of those who have yet to open a copy and to give some direction to those who, having read it, are still at sea as to the implications of the Report, it is planned that periodic articles will appear in the *Journal*, expressing points of view of well informed members of our association from widely separated parts of Canada.

One of the most precious attributes of life in a country such as ours is the liberty, the freedom that is the inherent right of each of us to think, to speak, and to act as our intelligence directs us. Basic to the exercising of this freedom is our necessity for a full and thorough understanding of every aspect of the matter in hand. Thus, varying points of view must be studied to avoid sectionalism or bias in the decisions that will be reached. With that point in mind, we shall present opinions favoring the proposed changes and those opposed to them with equal impartiality. The primary criterion that will mark the various contributors will be their intellectual integrity in meeting the challenge of the Report.

With these considered opinions as an impetus and guide to study during the remainder of this biennium, the time to be devoted to this topic at the next convention will be profitable and fruitful. Whatever the direction may be that decisions made then may take us, the nurses of Canada will experience a feeling of satisfaction that careful thought and a deep sense of their responsibility will have aided the voting delegates in reaching their conclusions.

A Christmas Wish? Nay, rather a prayer,
God guard thy footsteps everywhere;
Bless the work of thy hands for Him,
Grant that thy fair light ne'er may dim,
And set on thy forehead His seal divine;
That the world may read His life in thine,
And thou, in the peace earth cannot give
Or take away, mayest forever live!

High Energy Radiation Therapy Using Cobalt 60

H. E. Johns, Ph.D., F.R.S.C.

Introduction

For many years the trend in radiation therapy has been towards the use of higher and higher energy x-ray machines. With the high energy x-ray machines now available it is possible to deliver a very much larger dose to a tumor lying below the surface of the skin than to the skin surface. This is, of course, a very great advantage when a deep-seated tumor is being treated with radiation. With this in mind, radiotherapists have used two and three-million volt x-ray machines, 25 million volt betatrons, and a 70 Mev synchrotron is now being placed in operation for this purpose. The two- to three-million volt x-ray machines can be made mobile so that the x-ray beam may be aimed in any direction but the installations are very expensive and are rather complicated to keep in operation. The betatron and synchrotron types of machine are even more complicated and in many cases it is difficult to direct the x-ray beam from these machines to any required position.

In the last year two units using cobalt 60 have been placed in operation in Canada. These produce radiation very similar to a 3-million volt x-ray machine, are exceedingly simple to operate, and are much less expensive.

There is no doubt that many of these units will be used in various parts of the world within the next few years and it may be that they will replace, to a large degree, the more costly and complicated types of x-ray generating equipment.

At the present time cobalt 60 is a Canadian monopoly because we have in our atomic energy plant at Chalk River the only radioactive pile in the world capable of producing cobalt for these machines. The Canadian pile is known as a high flux pile. This means there is a very large number of neutrons dashing back and forth within the enclosed space within the pile. One gram of cobalt can be made from 25 to 60 times as powerful as the equivalent weight of radium. This high concentration of radioactivity is required for the successful production of a cobalt unit.

In November, 1951, a unit, designed and developed by the Eldorado Mining and Refining Company, was installed at the Victoria Hospital in London, Ont. The other unit was designed in Saskatoon and manufactured by the Acme Machine and Electric Company in Saskatoon for the Saskatchewan Cancer Commission. This unit was installed in the new University Hospital in October, 1951. Both

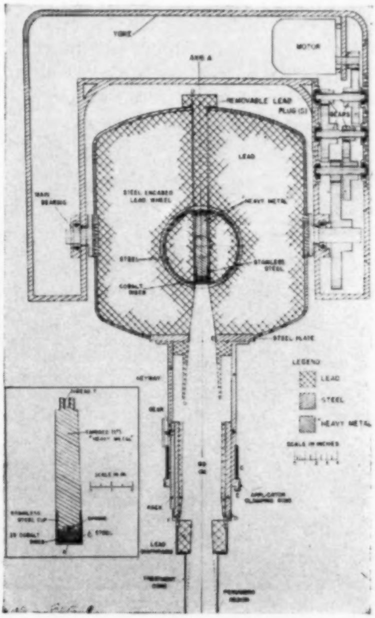


FIG. 1

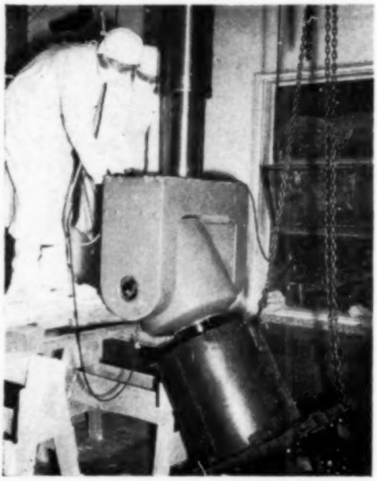
Schematic diagram of Cobalt Unit showing the position of the source on the circumference of the wheel at the centre of the head.

Dr. Johns is professor of physics, University of Saskatchewan, and physicist to the Saskatchewan Cancer Commission.

units use exactly the same strength source of cobalt but in external appearances are very different. From now on I will confine my attention to the unit in Saskatoon which was designed by me in collaboration with Dr. T. A. Watson, director of Cancer Services of the province of Saskatchewan, and Mr. L. M. Bates, a graduate student of the Physics Department, University of Saskatchewan.

SASKATOON COBALT UNIT

The construction of this unit is shown schematically in *Fig. 1*. The heart of the unit consists of the source of cobalt which is made up of 25 discs of cobalt, 1" in diameter, which were piled on top of one another to form a source about ½" thick. This source was produced and assembled by the Isotopes Production Branch in Chalk River and was shipped to Saskatoon in a lead container weighing about one and one-half tons. This shipping container can be seen in the lower part of *Fig. 2*. The unit was designed so that the source of cobalt could be transferred from the lead container to the head without personnel ever being exposed to the radiation. The source at Saskatoon contains the equivalent in radiation strength of about 1,500 grams of radium which, at the current price of radium, would sell for $30,000,000. For comparison one should realize that the strongest source of radium which has ever been used in a radium therapy unit has been about 25 grams. Our source, therefore, is about 60 times as powerful. Naturally great precautions had to be taken to ensure that the cobalt could be transferred from the safe to the head without mishap, as one would receive a lethal dose of radiation in a few minutes if one stood close to the source with no lead protection in place.



Star-Phoenix, Saskatoon

FIG. 2

Photograph of the transfer process of the cobalt from the lead shipping container (*below*) to the treatment head (*above*).

The head of the unit is a steel cylinder with rounded ends, filled with lead, at the centre of which is a wheel. The cobalt was mounted on the circumference of this wheel as can be seen in *Fig. 1*. To instal the source the lead plug "S" was removed and a rod inserted through the head along a diameter of the wheel and screwed into the source which was situated in the lead shipping container immediately below the head. The source was then pulled quickly into place. A photograph of the transfer process is shown in *Fig. 2*. The treatment head and the shipping container are bolted firmly together and a rod has been inserted along their common axis. The shipping container is below and the treatment head above.

Personnel is protected from the radiation because of their position above the unit. The rod is then unscrewed and the lead plug "S" placed in position. To turn the unit off, the wheel at the centre of the cylinder is rotated a half turn. This puts the cobalt behind the 7" of heavy metal. In all other directions the radiation is prevented from escaping by about 10" of lead. The whole head is suspended from a carriage which runs along a horizontal track near the ceiling of the room. A mechanism is provided to raise and lower the machine, to move the machine along the overhead track, and to rotate the machine to point the beam in any direction. These motions are controlled by a small push-button panel which hangs from the ceiling.

On the lower part of the head is connected a steel tube shown in *Fig. 1* on which may be mounted interchangeable treatment cones so that any size field of

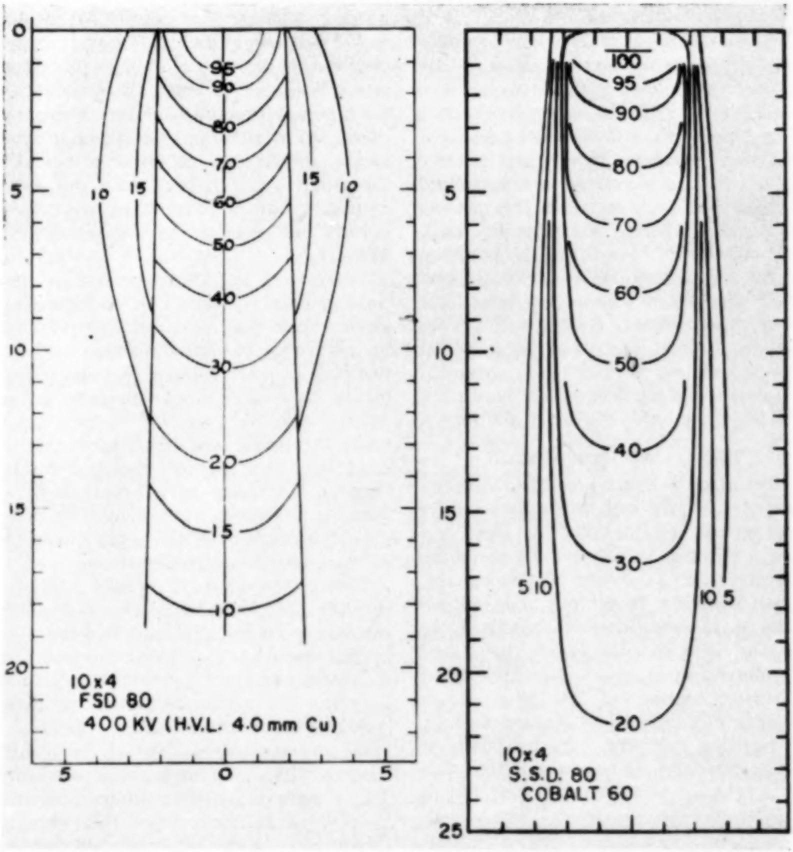


FIG. 3

Isodose distributions for two types of radiation. On the *left*—radiation produced by 4000,000 volts; on the *right*—radiations from cobalt.

radiation can be selected at will by the radiotherapist. These treatment cones consist of a lead diaphragm, which must be about four inches thick to stop the radiation from cobalt, and a stainless steel portion against which the patient is placed during treatment. The radiations from the unit are very penetrating so that the walls of the room are made of one foot of concrete. Even this amount of concrete will not stop the direct beam so that the basement storage room below the cobalt unit cannot be occupied when the machine is on. Even with walls of that thickness some radiation escapes and can be detected outside the room. However, this level of radiation is considerably below the tolerance value placed by health authorities.

The patient can be observed through a window cut in this wall. This window is filled with eight layers of plate glass, each one inch thick. One of the dangers in the cobalt unit is the fact that no noise is made when the unit is in operation in contrast with the betatron, for example, in which much noise accompanies the operation of the machine. It would be disastrous if the technician were in the room when the machine was operating. This is prevented by the use of interlocks on the doors. The machine cannot be turned on unless all the doors are closed and the timer on the control panel set for the required exposure time. When this is done the machine shuts itself off automatically when the present exposure time has been completed.

In the floor of the room is placed a steel table flush with the floor and eight feet in diameter. This table can be rotated by a motor outside the room and will be used in radiation therapy. In this type of therapy the patient will be held on this table with the tumor lying on the axis of rotation. With this arrangement the tumor will always be in the x-ray beam whereas a new skin surface will be brought under the beam as the patient rotates. With this arrangement the dose given the skin will be very small in comparison with that given the tumor.

RADIATIONS FROM COBALT

An ordinary inactive cobalt atom consists of a nucleus with 27 protons and 32 neutrons. When this cobalt is placed in a pile it becomes radioactive by absorbing a neutron from the pile. The radioactive cobalt then has 27 protons and 33 neutrons, giving altogether 60 particles in the nucleus. It is for this reason that cobalt is referred to as cobalt 60. This heavy cobalt, consisting of 60 particles, is unstable and the nucleus acquires stability by emitting two very powerful bursts of x-radiation and an electron. After this disintegration has occurred the atom is no longer an atom of cobalt but one of nickel. In the pile at Chalk River neutrons were added to cobalt to make it radioactive and, as the cobalt is used in the radiotherapy unit, these active atoms of cobalt emit radiations and change into nickel. In our unit about 1 per cent of the atoms were changed into this new form of cobalt and after many years this same 1 per cent will have changed into nickel.

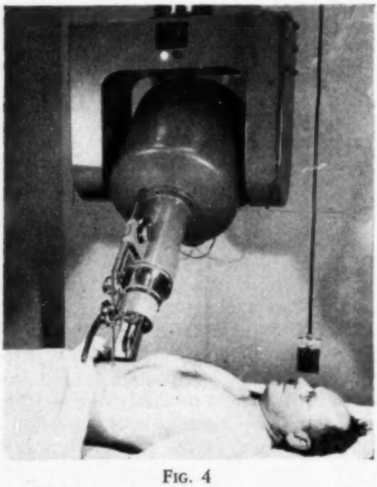


FIG. 4
Photograph of model being treated with the Cobalt Unit.

Fortunately the decay process is not too rapid. In 5.3 years half of the radioactive cobalt will have disintegrated and in this length of time our source will be one half as powerful as it is today. This means treatment times will have to be exactly twice as long. Of course, eventually the source will be so weak that it would not be a practical unit and at this time it will have to be replaced by a reactivated source. This should be considered analogous to the replacement of an x-ray tube in a standard therapy unit.

Before the unit could be used in radiotherapy careful investigations had to be carried out on the distributions produced by this radiation in a water phantom. It so happens that water absorbs x-radiation in about the same way as the human body. Measurements were, therefore, made on the cobalt unit, using very small sensitive electronic detectors of radiation. These devices for measuring radiation have been developed in the Physics Department of the University of Saskatchewan by a number of graduate students. The measurements were carried out by these students and by Miss S. Fedoruk, assistant physicist of the Saskatchewan Cancer Commission. Some of the results obtained are shown in *Fig. 3*. If we call the dose at the surface 100 per cent then we see that 10 centimetres below the surface of the skin a dose of about 50 per cent will be received. This should be compared with the distribution shown on the left-hand side of *Fig. 3*. This later distribution was produced with 400,000 volt x-radiations. With it we see that there is a dose of about 30 per cent at a depth of 10 centimetres.

The advantages of cobalt 60 over 400-kilovolt radiation are obvious. One should not assume that 400-kilovolt radiation is a poor source of x-radiation. These units cost 20 to 30 thousand dollars, weigh two to three tons, and are large installations. It is remarkable that without making any noise the cobalt can produce radiation much more penetrating than that produced by a 400-kv. x-ray machine. Indeed, extensive measurements show that the radiation is equivalent to that produced by a three-million volt x-ray machine. Finally in *Fig. 4* is shown a photograph of the unit being used in the treatment of a patient. In this unit there can be seen the lead-filled cylinder, the supporting mechanism for the unit, and the treatment cone attachments. The control panel is seen in the foreground.

CLINICAL RESULTS

There has been much written about cobalt being a new cure for cancer. This, of course, is an exaggeration. Cobalt supplies a new technique for the treatment of cancer which may be more convenient to use than the types of x-ray equipment which have been on the market up to the present time. We should consider cobalt as one more device to aid in the fight against cancer but we must not be led to think that it is a new cure. To date several hundred patients have been treated by Dr. Watson with the Saskatoon unit, with some very satisfying results.

Migraine

ALEC S. BARNUM, M.D.

Since the earliest recording of medical knowledge, the problem of headaches has been noted and, from a conglomeration of writings, the entity today defined as migraine emerged as early as the first century of the Christian era, notably in the writing of Aretaeus of Cappadocia. This is not surprising when we note the common occurrence of this affliction.

You all know her—perhaps you trained with her—the young girl who, normally healthy and cheerful, was periodically seized with a severe and incapacitating headache which was usually preceded by flashing of lights before her eyes and was accompanied by nausea, retching, and confinement to bed in misery until sleep brought the much needed respite from her wretchedness and malaise—that is, until the next attack. She told you she had "migraine" and you, of course, knew it meant "sick headache." However, what is this "migraine"? What does this word mean? What does it imply? What is its cause and its treatment? Why should she and not you be so afflicted? It is with these problems that we shall be concerned.

Migraine may be said to include those headaches which occur in a normally healthy person in a periodic fashion and are preceded by visual disturbances, are usually unilateral, are accompanied by nausea and vomiting and followed by drowsiness and sleep. The duration of the attack varies from 15 minutes to as long as 10 days, the usual duration being about 12 hours. The frequency of the attacks likewise is highly variable—some patients having several attacks a day and others only once a year. Once every two weeks, or once a month, is the most frequent incidence.

The above definition is, of course, subject to many variations, as will be shown later.

Because of the usual unilaterality of the headache, Aretaeus called it "heterocrania," Galen later changing the term to "hemicrania." The exact Latin equivalent of this term was "hemicranium" which became modified in low Latin to "hemigranea," later to be abbreviated to emigranea," "migrana," and in the later French translation to "migraine," the term most widely recognized today. For further historical data, one is referred to the excellent review of this subject by Riley$_3$.

The incidence of migraine in the

Dr. Barnum was with the Neurology Service of the Montreal Neurological Institute when he prepared this paper.

general population is difficult to evaluate as not all sufferers have it to such a degree that it requires medical consultation. Of those known cases, it has been estimated that females are more frequently afflicted than males, the most agreed upon ratio probably being 2:1. The usual age of onset is in the "teens" or "twenties" and 80 per cent of cases appear before the age of 40. There have been cases reported as early as two years of age and as late as the sixth decade.

Heredity seems to be a definite factor in migraine, most writers stating that at least 50 per cent of offspring of parents with migraine will also suffer from this disorder. There seems to be greater transmissibility through the mother, Flatau estimating 79 per cent, as opposed to 21 per cent through the father, in his studies. Others have opposed this view.

The relationship of migraine to other diseases is an interesting problem. Alcoholism, gout, family periodic paralysis, allergy, and seizures have been mentioned as associated conditions both on a hereditary and coexistent basis. The most clear-cut connection, however, is that of migraine and epilepsy—and, indeed, some writers feel that migraine itself is merely a sensory form of epilepsy. Certainly there is a strong hereditary association of the two. Ely, has indicated that inherited tendency toward migraine resulted in a greater predisposition to convulsive seizures than did a family history of convulsions themselves. He also noted that of 171 patients with convulsive disorders, 15.2 per cent also had migraine and, of 104 patients with migraine, 7.6 per cent also had convulsions. It is a common clinical experience to see a patient with migrainous attacks have a later occurrence of seizures and, in some instances, have the migraine disappear and give way to convulsions, one condition seemingly merging into or exchanging for the other. One should not emphasize this aspect too greatly, however, as certainly the majority of patients with migraine do not and will not have seizures. Unfortunately, electroencephalographic studies on migraine patients do not bear out the clinical impression of a close relationship in mechanism between the two, as there seems to be no constant E.E.G. picture in patients with migraine. It is an interesting problem and one that needs future clarification.

The clinical types of migraine are variable and we have already discussed the usual clinical picture. Attacks are seen presenting autonomic phenomena beside nausea and vomiting, such as pupillary dilatation, salivation, flushing of the face, angioneurotic edema, nasal congestion, Horner's syndrome, lacrimation, sweating, temperature changes of the extremities, "goose flesh," vasovagal fainting attacks, respiratory rate changes, cardiac symptoms, frequency of urination, etc. There may also rarely occur attacks involving mainly the motor system as manifested by local twitchings, weakness or paralysis of one or more limbs, aphasia, or choreiform movements. Similarly, cerebellar symptoms, such as dizziness and ataxia, may predominate.

Most frequent are the sensory types, however, and one may see transient hemianopsia, or tingling of one side of the body or about the mouth, with an attack. These, like the motor symptoms, are most often confined to the upper extremities. Psychic phenomena are also seen — retardation of thought and memory, confusion, and sometimes transient psychosis. Abdominal migraine is seen as transient attacks of severe abdominal pain with vomiting. This is sometimes a stumbling block in misdiagnosis of a surgical abdomen. More common are the ophthalmic types which are confined to eye manifestations such as clouding of vision, flashing lights, or even temporary complete blindness. Complete ophthalmoplegia, with inability to move one or both eyes, may occur. Facial paralysis has also been noted in attacks.

What, then, can be the mechanism of this condition which can explain so many and variable symptoms? There have been many theories postulated including: reflex irritation from the eyes, mechanical irritation of the brain and its coverings, endocrine unbalance (migraine attacks appear more frequently at the time of the menstrual period), allergy (there seems to be a close hereditary and personal history of allergy in patients with migraine), stasis in the gastrointestinal tract, disorder of the pituitary, toxic factors, etc. Actually, the cause is not known. The most workable theory is that there is a sudden vasoconstriction of the vessels of the brain and sometimes retinae with transient anoxia, depending upon its site. Thus, anoxia of the sensory cortex would give rise to tingling in the part there represented, or anoxia of the part of the occipital cortex or retina to visual phenomena. The fact that thrombosis of vessels with permanent disability has been seen following attacks would lend support to this mechanism. Following the period of vasoconstriction, there is a reactive vasodilation and this is thought to give rise to the headache. One is referred to the work of H. G. Wolff(5, 6) and his collaborators for an excellent review of the vascular mechanisms of headache. The vascular explanation serves to explain the immediate phenomena but one must clarify the mechanisms underlying these vascular changes. Psychic factors have been mentioned, as migraine is most frequently seen in a hard-driving, compulsive personality. Allergy, hormonal, and biochemical factors have been mentioned. Which factor, or combination of factors, are responsible is yet to be exactly determined.

The treatment of migraine has advanced considerably from the first-century method of applying a hot iron to the head or the incision of the scalp and introduction into the cavity of a piece of garlic which was covered by a dressing for about 15 hours, then removed for two to three days when the wound was dressed with butter-soaked cotton until it suppurated!! Today the most useful drugs are those of the ergot series which act by causing vasoconstriction. Hence, if administered early in an attack, the reactive vasodilatory phase is averted and the headache does not appear. Ergotamine Tartrate by injection, Dihydroergotamine, and Cafergone (combination of caffeine and ergot) are probably the most frequently used. The antihistamines have been found useful in some cases where an allergic factor is thought to be present, although this action is not always consistent, even in the same patient. The daily use of a mild vasodilator agent has been suggested as perhaps worthwhile in preventing the initial vasoconstriction. Such drugs as Priscoline have been tried in this respect. The results of such therapy are not as yet definite enough to evaluate. There are many other suggested treatments but the results in each case must naturally depend on the mechanisms involved and the balance of mechanisms is undoubtedly variable from case to case. Further investigations will, we hope, clarify just what these mechanisms may be and upon which of the multitude of various factors, both psychic and somatic, they are dependent. Only then will our understanding, and hence our treatment, be rational and 100 per cent effective.

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Letter to Student Nurses

After reading your address in *The Canadian Nurse*, I am writing on behalf of three other nurses and myself hoping that you will be able to help us.

We wish to correspond with nurses from your country and learn about the conditions in your hospitals, as we are very interested to know all we can so that at the completion of our training, in two and a half year's time, we can visit your country and maybe nurse there.

We four are in our first year of training at the Dunedin Public Hospital which as you will know is connected with the New Zealand Medical School. We are in our 20th year and our names are as follows: *Adrienne N. Kennedy, Anne Macdonald, Beverley J. Miller, Patricia A. Robertson.*

NURSES' HOME,
CASTLE STREET,
DUNEDIN, NEW ZEALAND.

Symptomatic Management of the Allergic Patient

C. H. A. WALTON, M.Sc., M.D., F.A.C.P.

Throughout these papers I have attempted to show the value of the allergic theory. In many instances specific allergens can be identified and appropriately dealt with, either by separating them from the patient or by specific desensitization. It should be the physician's duty in any of the allergic diseases to make every effort to find the allergic basis for the patient's symptoms. If he can do so the outlook is good. However, during the course of investigation, even if successful, the patient must have symptomatic help. Further, there is the large group of cases, of perhaps a third or more in number, in which no specific allergens can be found. In such cases one must resort to symptomatic therapy. There is also the group of cases in which there are demonstrable allergens which cause trouble but in which all of the allergic agents cannot be found or dealt with satisfactorily. These patients also require much symptomatic management.

ALLERGIC RHINITIS

In the past few years valuable agents have been produced which are very effective in more than 80 per cent of these cases. These are the chemical substances which can be classified as antihistamine drugs. These drugs have many common characteristics chemically and are similar pharmacologically. They vary in their efficiency and in their toxic effect. The earlier drugs developed in this group continue to be among the most valuable.

Neo-Antergan, the first clinically efficient antihistamine, produced in the Pasteur Institute in France, is still one of the best. Pyribenzamine is closely related chemically and pharmacologically to it. Benadryl, the first one available on this continent, is very effective but has the disadvantage of a high proportion of toxic effects, the chief of which is its hypnotic property. Occasionally this hypnotic property is valuable but more often it is a nuisance. It is not possible nor is it desirable to review the properties of all of the many antihistamine drugs on the market. The physician should use the one with which he is most familiar. Dosage, of course, varies with each product. Generally, an effective dose lasts from four to six hours before symptoms return.

Ordinarily antihistamine drugs are given orally and are quite effective by this means. However, it should not be forgotten that the drug can also be used topically. In solution, Neo-Antergan, and several of the others which are soluble, can be sprayed in the nose with good effect. They can also be used as drops in the conjunctivae with good symptomatic relief. These local effects are particularly valuable for immediate effect and also can be used when the toxic effects from oral administration are undesirable.

In a small proportion of cases in which the antihistamine drugs are ineffective, one of the several sympathomimetics may be used. Ephedrine locally is helpful but unfortunately there is generally a severe reaction afterwards. Privine solution applied to the nose and eyes is very effective but has the bad quality that, in many instances, after prolonged use it will produce very severe and often intractable rhinitis medicamentosa. For this reason, in my opinion, Privine should never be prescribed because the patient will continue to fill the prescription without your knowledge and very often serious harm will result. Privine in its more dilute form mixed with Antistine in solution seems to have avoided the difficulties of the original Privine solution and its use seems to be justified when other measures fail.

Although the causative agent may not be definitely identified, it is probably wise, when dealing with intractable and

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Dr. Walton is with the Division of Medicine, Winnipeg Clinic, Man. This valuable material is reprinted from *The Bulletin* of the Vancouver Medical Association, with permission.

particularly perennial allergic rhinitis, to remove feather pillows, substituting sponge rubber, and to minimize the amount of atmospheric dust, particularly animal and household dust to which the patient might be exposed. Occasionally it is possible for people suffering from pollinosis to leave the area in which their particular offending pollen is prevalent for its season. It is rare that a patient has sufficient resources to accomplish this and other measures are, therefore, necessary.

BRONCHIAL ASTHMA

Whether or not specific dust allergens are demonstrated, it is highly important for all asthmatics to live in as dust-free an atmosphere as possible. Feather pillows should be removed and foam rubber pillows substituted; animals in the house should be forbidden; other notably dust-producing environments such as grain elevators, industrial atmospheres, etc., should, if possible, be controlled. Fresh paint causes severe trouble in most asthmatics. Odors from cooking, particularly frying and burning grease, are highly irritating. Pungent odors, irritating gases, strong perfume, and heavy local dust may precipitate trouble quite apart from any demonstrable specific allergy.

The asthmatic patient is understandably anxious. He wants help as quickly as possible. He is suffering from anoxia. A good rapport between patient and physician is of the greatest value. If the patient's confidence can be restored other measures are apt to be more effective.

In this disease the sympathomimetic drugs, particularly Epinephrine, are still the most useful and have been for more than a generation. Epinephrine or adrenalin is used hypodermically and the dose should always be small. In general, three to five minims, that is a fifth to one-third of a cc. of the 1:1,000 solution of the hydrochloride is adequate. It is very important not to give larger doses because of the great excitement and tachycardia which are commonly produced as side-effects. It is seldom that larger doses have any more beneficial effect on the bronchi and they always have an unfavorable effect on the patient as a whole. Small doses given frequently in different sites are very much more effective and less troublesome than one large dose. Long-acting or "depot-type" adrenalin has been disappointing.

There is no reason why a stable and dependable patient cannot be taught to give adrenalin to himself. This is no more difficult than teaching the administration of insulin. Perhaps a member of the family could be taught to give the drug. I do not think that any harm will result from this, although, in dealing with depressed patients or those who are unreliable, there is danger. I have known of suicide from overdosage with adrenalin. Obviously, such risks occur with all drugs and should not prevent us from using them intelligently.

There are many forms of sympathomimetic drugs available. Ephedrine in the form of the hydrochloride is effective orally as distinct from Epinephrine which is only effective by the parenteral route. Ephedrine has the drawback in many cases of causing a great deal of excitement and tachycardia. This is less troublesome in children than in adults. Various synthetic analogues of this drug are also available, prescribed in proprietary mixtures, associated with phenobarbital, which cuts down the excitement, and aminophylline. Such oral preparations are very valuable for milder cases. Another drug of this series is Aleudrin which is sold under various trade names. It is effective by inhalation, by injection and sublingually. These are all useful forms and are effective in the milder cases.

Epinephrine is useful by inhalation but there is clinical reason to believe that if it is used excessively, over a long period of time, the patient gets steadily worse and there may even be damage to the bronchial mucosa. All of the patent asthma sprays sold in drugstores consist of Epinephrine in some form. Many asthmatics reach the stage when adrenalin or one of its related sympathomimetic drugs is no longer effective. This ineffectiveness is usually only temporary and other measures become necessary in the interval.

Aminophylline is an extremely valuable therapeutic agent in asthma. Given orally it is of small value although when combined with Ephedrine it seems to be of some use. Generally speaking, it is impossible to give a sufficiently large dose orally to obtain an adequate effect without causing nausea and vomiting. However it is exceedingly valuable when given intravenously in cases of intractable asthma. The drug should be given very slowly and well diluted. The average dose in an adult is 7½ grains (half a gram), in a solution of at least 200 cc. of 5% glucose and water. It should never be given directly from the ampoule. Serious accidents have occurred and even fatalities reported. One cannot stress too greatly the *necessity of dilution*. This fact, of course, limits its use usually to hospital. However, there is a very useful though little known solution for this difficulty. Aminophylline dissolved, in a proportion of 7 to 10 grains in 20 cc. of distilled water, can be administered per rectum with an effect which is very nearly comparable to the intravenous route. This is a simple technique. The patient can carry it out for himself with simple instructions.

If it is considered more convenient, the drug can be given in a suitable rectal suppository. A disadvantage of this method is cost, which is several times that of the aqueous solution, and the fact that the suppositories tend to harden and become less soluble with time and storage. Occasionally aminophylline leads to extreme central nervous excitement. This may make its use impossible in small children who are apt to show this peculiarity.

Potassium iodide is still the most useful expectorant in this disease. Given in small doses of from three to five grains, two or three times a day, the thick gluelike mucus may often be expectorated with considerable ease and benefit to the patient. It is not necessary to give the drug for any great length of time. Frequently the patient can be taught to decide when to use it. One should again sound a word of warning that iodism may occur and in an allergic patient we sometimes see a very severe iodide rash which may be most refractory to treatment.

The various asthma smokes, which are usually variations of stramonium leaf, are effective symptomatically in moderate cases. They have the obvious objection of causing a very unpleasant odor in the house and they soon leave the patient in need of other measures. In general, there is little or no place for their use in clinical medicine.

The severe cough, which is so troublesome in many cases, may respond satisfactorily to sympathomimetic drugs and to iodides but occasionally it is necessary to use cough sedation, and a simple syrup containing small amounts of codeine, perhaps combined with some expectorant such as ammonium chloride, is often very helpful. Codeine is the one opiate used in small doses which appears to be safe in asthma.

Because of the patient's agitation and anxiety, sedation is also useful. Sedation should never be carried to the state of making the patient unconscious or difficult to rouse. He may be distressed but he requires to be alert so that he may fight his difficult dyspnea and not succumb because of lack of effort. Mild sedation, in the form of barbiturates, bromides or chloral hydrate, is highly useful. Asthmatics have died from large doses of barbiturates and when given intravenously in the form of sodium amytal there is great danger.

As cyanosis is common, oxygen should be given freely. If a mixture of oxygen and helium is available it has considerable use when given skilfully and not wasted.

Anesthesia has been thought for a long time to help the severe intractable asthmatic. Some anesthetic agents are decidedly dangerous. Intravenous anesthetics should never be used and may lead to a fatal result. To date the only really safe anesthetic is ether. When given by inhalation with full oxygenation the patient not only sleeps during the anesthetic but is often easier afterwards. Ether can, of course, be administered rectally mixed with olive oil. Such administration should be carried out by those skilled in anesthesia and with a nurse in attendance to watch the patient, because it is desirable that a deep stage of anesthesia be obtained. This form of treatment was developed because it was observed that asthmatics were often better after a major surgical operation for a considerable period of time.

There is much reason to believe that the anesthetic is only part of the story. Apparently the surgical trauma is of major importance. I have never seen a case of intractable asthma do as well from simple ether anesthesia as I have in several instances when major surgery became necessary. Often the patient had a remission lasting for many months. Sometimes in a desperate situation one might almost wish that a surgical procedure was necessary.

If the attack of asthma is prolonged for more than a few hours, functional emphysema develops. If the asthma persists for a long period the emphysema may become permanent. It is highly desirable to anticipate this development and to teach the patient correct breathing exercises with particular emphasis on proper expiration. The asthmatic ordinarily attempts to limit expiration as much as he can with the result that the sticky mucus tends to remain in his bronchi causing a semi-permanent bronchial obstruction. A physiotherapist, specially trained in the technique of proper breathing exercises is a great help. Have her teach such a patient and supervise his exercises from time to time.

It is perhaps trite to say that attention to the patient's nutrition is desirable. In a severe prolonged case of asthma this is, indeed, often very necessary. The patient should not be confined to bed. If he is more comfortable in a chair he should certainly be permitted to use one. If he is able to go to the bathroom without too great aggravation of his dyspnea, this should be permitted.

In all instances ambulation and full activity should be restored at the ealiest possible moment. In this connection it is particularly important to emphasize that children should not be invalided any more than is absolutely necessary because of asthma. It is sad on many occasions to see a child who, because of a severe asthmatic attack, has been confined to his home and even perhaps to bed long after the attack has subsided, thus missing much school and creating a form of invalidism which may be difficult to treat.

Antihistamines are without value of any kind in the treatment of bronchial asthma. The only exception to this rule may be in infancy. If there is a concomitant allergic rhinitis antihistamines may be of indirect value.

URTICARIA AND ANGIOEDEMA

Antihistamines are very effective symptomatically in at least 80 per cent of urticarial cases. Ordinarily it is sufficient to give them by mouth in doses appropriate to the drug chosen. A favorable effect may last from four to six hours. If the case is very severe and, in particular, when dealing with cases following the use of antibiotics in which there is great disability and suffering, it is sometimes desirable to administer the antihistamine drug intravenously. A most suitable form of this is Neo-Antergan. Antistine is also available in this form. The drug should be given directly from the ampoule in doses of 50 mg. with a small gauge needle and very slowly. Fifty mg. in this way will give dramatic relief in most instances and it is very much more effective both as to dosage and time than the oral route. If a hypnotic effect is necessary the drug Phenergan is also available by the intravenous route and is highly effective.

The antihistamine drugs also may be given rectally if desired. This is valuable sometimes in small children or in adults when vomiting occurs. Epinephrine hypodermically is, of course, effective but it is seldom necessary to use it. Ephedrine and its related drugs, by mouth, also is of some help but the occurrence of excitement and palpitation usually is a drawback. Sedation is very important in this disease because the psychogenic factors are often prominent. Small doses of phenobarbital repeated at suitable intervals may be of the greatest help.

ATOPIC DERMATITIS

This is not the occasion to discuss local applications in this disease nor am I sufficiently familiar with dermatology to discuss the great variety of local applications that might be used. Very often it is worthwhile to discontinue all the many applications that the patient has previously used because of the locally irritating effects which they often have. Pruritus is a very common and distressing feature of atopic dermatitis and if it can be relieved the skin will often benefit greatly. For this reason it is desirable to try the effect of a suitable antihistamine drug. In somewhat more than 50 per cent of cases these drugs give such relief in easing the itching that the patient benefits considerably. Obviously in dealing with this disease known irritants such as wool, soap, etc., should be removed from the patient's immediate environment.

Contact dermatitis is best dealt with by removing all possible irritants from direct contact with the skin. Itching, again, can be often helped by the use of suitable antihistamine drugs. These cases are usually self-limited and local applications are only of temporary help. Soothing lotions and the use of such substances as potassium permanganate, ferric chloride, etc., have definite value still.

MIGRAINE

One almost hesitates to discuss the symptomatic management of this most distressing illness. The attacks often come on without warning. Frequently it is impossible for the doctor to reach the patient early enough to be of any real aid. The administration of a suitable ergot preparation, such as dihydroergotamine, given early in the attack and preferably intravenously will often have a dramatic and beneficial effect. Oral ergot preparations are, on the whole, disappointing. The one known as Cafergone, which is a form of ergotamine and caffeine combined, is sometimes effective when given early enough and in an adequate dosage. The patient who has a clear-cut aura can often use such drugs early enough to abort the attack. Of course, rest and sedation are most valuable at this stage.

In a few instances the administration of a suitable antihistamine drug, when the attack is impending, may be effective in preventing an attack. These cases are not as numerous as we would like but they do occur and are most gratifying. The ordinary analgesic drugs are virtually useless in this disease. If vomiting is severe the patient may need supportant therapy in the form of intravenous glucose saline.

GASTROINTESTINAL ALLERGY

One would hesitate to make a diagnosis of gastrointestinal allergy without being able to demonstrate the cause. The treatment, of course, is its removal. If this reasoning is correct, the patient might well be starved at the time of the attack and limited only to water. The use of atropine, or some of the atropine-like drugs, is often very helpful in relieving symptoms, particularly the crampy pain which is so characteristic.

GENITOURINARY ALLERGY

In the few genitourinary allergies that I have seen, the administration of antihistamines has been effective. In these cases, too, small doses of adrenalin might be useful. It would also appear that in some instances of dysmenorrhea adrenalin and perhaps the antihistamines have some use.

MOTION SICKNESS

While this disease is not known to be an allergic phenomenon, it has been observed that patients suffering from allergy who also suffer from motion sickness benefited when they were given an antihistamine drug. The first of these drugs which was very effective and which received world-wide publicity is called Dramamine. Dramamine is, indeed, effective in the treatment of and prevention of motion sickness whether it be in a ship at sea, a train, a motorcar, or an aeroplane.

It is now known that all of the antihistamine drugs have this same property in some degree and are effective in allergic and non-allergic people alike. If a child vomits every time he is taken for a drive in a car, give him a tablet of Neo-Antergan or Pyribenzamine or some Benadryl before he starts and the trip will be enjoyed very much more. In the case of people crossing the ocean the same principles apply. It would be wise to supply them also with a few antihistamine suppositories so that if they forget to use their drug and start to vomit the drug given rectally can restore them to reasonable comfort.

DESENSITIZATION REACTIONS

When using potent extracts for the treatment of allergic persons there is always a real risk of precipitating a severe general reaction. Such reactions are alarming and some have been fatal. The prompt use of Epinephrine, tourniquets, etc., is, of course, necessary but it is useful to remember that an intravenous injection of a suitable antihistamine (e.g., 50 mg. of Neo-Antergan in 2 cc.) will frequently give rapid and striking relief. An ampoule ready for instant use is now as important as Epinephrine when carrying out testing or treatment in allergy.

Acth and Cortisone

The recent advent of these two extraordinary substances has produced the most amazing therapeutic revolution in medicine. Their extraordinary and unexpected effects in producing beneficial results in the most diverse diseases—diseases which we thought were quite unrelated in any possible way—have led to some startling results. Early in their clinical trial it was noted that one of the effects of the administration of the adrenocorticotropic hormone or of Compound E, now known as Cortisone, was to reduce the number of circulating eosinophils to the vanishing point. This phenomenon is, of course, the basis of the Thorn test.

Four years ago in Montreal, Bram Rose and his associates demonstrated that tropical eosinophilia and Loeffler's syndrome responded dramatically to Acth. It is not surprising, therefore, that Cortisone and Acth should be used in various forms of allergic disease. This is not the time to discuss the theory of their action nor give in much detail the wide experience that has accumulated. In general, Acth, which is a product of the anterior lobe of the pituitary gland, acts by stimulating the adrenals to produce a number of secretions, among them Compound E or Cortisone. Thus, the clinical effect of the two hormones is similar and when they differ it is probable that the adrenal is producing other effective substances than Compound E. In fact it would appear that Kendall's Compound F is much more effective than Compound E (Cortisone) in allergic disease. It is probable that Cortisone is not the normal cortical secretion but the Compound F is.

Generally, neither of these drugs would be justified for the treatment of such a disease as allergic rhinitis, effective though they are. They have, of course, also been shown to be effective in dealing with urticaria, atopic dermatitis, etc., but there is little indication for their use in these diseases.

Cortisone used as a nasal spray has been of some value in our experience. One hundred mg. are suspended in about 15 cc. of a normal saline solution or a 1:3,000 solution of Zephiran and the resulting solution sprayed by means of a nebulizer into the nose. Good symptomatic results may occur for a short period. The spray has to be used every hour or two for a good effect and it is extraordinary how polyps will sometimes shrink and almost disappear under such management. If nasal obstruction is chronic and polyposis severe, Acth or Cortisone in full therapeutic doses may be justified. The growth is then kept in control with a Cortisone spray. Experience only will tell if such management is ever justified to replace surgery.

The greatest use for the two drugs is in intractable asthma. There can surely be no excuse, other than clinical research, for using them in any other form of asthma. Apart from the usual contraindications which are so well known, I would stress, in particular, heart failure and hypertension. Two of the major objections to the use of the drugs may be listed—first, they must be repeated at frequent intervals, often under difficult circumstances; and, second, they are much too expensive for ordinary use. One might add that no one yet knows what continued use of these substances would do to a patient over a long period of time. However, when one is dealing with a case of intractable asthma, in the full meaning of that term, there can be little doubt that one is justified in using either of these two endocrine substances.

Cortisone in a suitable dosage is sometimes dramatically effective in relieving asthma. Often, though, it is rather ineffective and disappointing. Fortunately, the drug can be used effectively by mouth and this makes its use very much simpler and certainly cheaper. If there is any doubt that it has not been effective by mouth, then it can and should be administered intramuscularly. Generally, 300-400 mg. is given in the first day and the dose gradually reduced over a period of several days. It should not be continued indefinitely for fear of producing adrenal atrophy. During its administration salt should be restricted and it is desirable to follow the effectiveness of the drug by daily eosinophil counts. Cortisone is also effective when inhaled as an aerosol but there seems to be no practical advantage in this method.

Acth gives much better and more consistent results in the treatment of intractable asthma. It, too, has a great drawback in the necessity of giving it parenterally at six-hour intervals. It has been found by experience that an interval longer than six hours greatly reduces the effectiveness of the drug. It is our practice and the practice of many centres to start with a dosage of 25 mg. subcutaneously every six hours. This is given for a period of 48 hours or until the patient shows marked improvement. The amount of the drug may then be progressively reduced, perhaps to 15 mg. then 10 mg., and so on, but always at six-hour intervals. In a favorable case dramatic response will occur after 250-300 mg. but not infrequently doses up to 500 or even 700 mg. are necessary to produce a satisfactory remission.

During the administration of Acth the patient must be on a salt-free diet, should be weighed daily, and observed carefully for any toxic effects. Recently it has been demonstrated that Acth is more effective in smaller doses when given by continuous intravenous infusion (5% glucose in water). This technique when practicable seems to give the best results and to be more economical.

The results are often, indeed, dramatic. A severely dyspneic patient breathes normally, his emphysematous chest shows good breath sounds, his morale rises, he sleeps well and suddenly a very sick patient becomes a well individual. Very occasionally his euphoria may become abnormal and almost amount to a psychosis.

On occasion a patient will fail to respond to full doses of Acth. Often the initial eosinophil count is very low and drops little, if at all. One can only presume a failure to stimulate the adrenal cortex. Such a case may respond dramatically to Cortisone. In one patient in which this occurred an operation for a prolapsed intravertebral disc also failed to benefit her. This seems to support the idea that major surgery exerts its benefits on asthmatics through stimulation of the pituitary or the pituitary adrenal axis. Her adrenal cortex failed to respond to either form of stimulation.

It must always be remembered that the dramatic remission is usually short-lived. The patient and his family must be warned that symptoms will recur as severely as they were to start with, either in a few days or weeks or, in a very rare case, in a few months. The ensuing disappointment, even when expected, is very great and may create a serious psychological problem, particularly if money is in short supply.

I believe that there is a place for the use of these substances in intractable asthma but that place is limited and perhaps their greatest value will lie in the greatly improved clinical knowledge of these diseases which we will derive. Even now, our understanding of asthma and many other diseases has been greatly enhanced by the use of these products. Our knowledge of the pathological physiology of many diseases will undoubtedly be greatly helped by careful observation of the patient under treatment with Cortisone or Acth. It may be seriously doubted if Acth or any of the adrenal corticosteroids will ever become widely used as therapeutic agents in allergy but there is much reason to hope that their use will advance our knowledge greatly.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Helen Etherington,* formerly with Hamilton Department of Health, and *Mrs. Walter (Stewart) Best* (Hamilton Gen. Hosp. and University of Toronto general course) to Wentworth County school health service; *Grace Latham* (St. Mary's Hosp., Timmins, and U. of T. gen. course) to Oshawa board of health; *Mrs. Anna Jean Glover* (B.Sc.N., University of Western Ontario) and *Frances MacDonald* (Hotel Dieu, Cornwall, and McGill University public health nursing course) to Windsor board of health.

Resignations: *Pearl Stiver* as public health nursing director, Ottawa board of health, to become general secretary, Canadian Nurses' Association; *Marian Hatcher* from Galt board of health to go with WHO; *Thérèse Rathier* from Prescott and Russell health unit; *Laura Wheelband* from Halton Co. health unit.

International Red Cross Conference

Florence H. M. Emory

From July 23 to August 9 this year Canada was hostess to a conference which brought to our very doors a consciousness of the international significance of the Red Cross movement as a potent factor in the building of health and the maintenance of peace. To it came delegations from some 60 countries which included in most instances both voluntary and official representation. In addition, observers were in attendance from many international and national organizations, among them the International Council of Nurses and the Canadian Nurses' Association. Thus, under the banner of the Red Cross, which is "the sole international humanitarian organization to which all nations can and do belong," were convened sessions through which much of a positive nature was accomplished and this in spite of the constant interjection of certain matters of a political nature. Surely to have had social contact over a considerable period of time and to have participated in debate, which at times reflected wide divergence in purposes and philosophy, should have a salutary effect, as the members of the conference return to push forward Red Cross interests in their organizations and thus to contribute forcibly to the ideals of health and of peace throughout the world.

Bodies Constituting International Red Cross

It will be well at this point to note the bodies which constitute International Red Cross. There are two. On the one hand there is the International Red Cross Committee, a group of Swiss citizens which exists to promote the formation of national Red Cross Societies, to further international humanitarian agreements, and to serve as a neutral benevolent intermediary in time of war. On the other hand is the League of Red Cross Societies with a membership of some 70 national associations, coordinating their activities and promoting Red Cross ideals and services in the affiliated national groups. All told, the Red Cross movement constitutes a formidable body of lay opinion throughout the world. In conference discussion the invective of the Communist countries was directed towards the International Red Cross Committee — its functions and activities — rather than the League of Red Cross Societies.

Reports of Special Interest

Nursing interests were reflected in a very special way in two reports presented—that of the Nursing Advisory Committee of the League and the report of the Health, Health Personnel and Social Assistance Commission of the International Conference. The first of these included strong recommendations which were supported and commented upon by the representative of the International Council of Nurses. They emphasized:

1. The importance of home nursing, taught by competent instructors, in relation to the contribution which can be made by volunteers so trained to certain phases of community health service, and thus to the shortage of nurses.
2. The need for continued assistance through bursaries and scholarships in the preparation of nursing personnel.
3. The value of studies sponsored by the National Red Cross Society and the national professional nursing association jointly in relieving the shortage of nurses.
4. The contribution which can be made by the National Red Cross Society in interpreting the need for high standards of nursing service.

The report of the Health, Health Personnel and Social Assistance Commission made recommendations concerning such matters as medical equipment, blood transfusion, artificial respiration, and social assistance. Relating to methods of artificial respiration, the following resolution was adopted:

The 18th International Red Cross Con-

Miss Emory is Honorary Adviser in Nursing, Canadian Red Cross Society, and representative of the International Council of Nurses.

ference, recognizing the superiority of the Holger-Nielsen method of manual artificial respiration over the majority of other similar methods, particularly in respect of pulmonary ventilation, ease of execution and simplicity of instruction, recommends that the Holger-Nielsen method of artificial respiration be adopted as soon as possible for general basic instruction of Red Cross personnel; this should not exclude, however, the teaching of other methods of artificial respiration for use in special circumstances and conditions.

Madame Gillet's report concerning the Relation of Red Cross to Social Assistance was of special import in timing and content. It was decided that a study of this matter by a technical expert should be continued and the findings made available to national societies. A copy of these documents can be obtained from the headquarters of the League in Geneva, Switzerland. Space forbids the inclusion of resolutions emanating from the other three commissions of the conference—namely, the General Commission, the Relief Commission, and the Junior and Youth Commission.

CERTAIN GENERAL IMPRESSIONS

1. In International Red Cross is centred a movement both humanitarian and scientific which enlists intelligent lay support in the interests of health and of peace.
2. To these ideals the International Committee of the Red Cross and the League of Red Cross Societies (which represents the membership of more than 70 national associations) are committed.
3. Nursing plays an important part in Red Cross activities, having been given a unique role in assisting to implement Red Cross ideals.
4. In Red Cross is exemplified an international body of lay opinion which synchronizes closely with government and with kindred world organizations, both official and non-official.
5. Within the Red Cross body there exists a cleavage in thought and ideals between communism and democracies. Much patience and tolerance is needed if these groups are to continue to march under the Red Cross banner.
6. In spite of inherent difficulties, through discussion and social intercourse, the conference took constructive action towards the achievement of its ultimate goals of health and peace.

CONCLUSION

The writer wishes to record the fascinating quality of the sessions as a whole and the stimulus derived from the fact that for a period, all too brief, Toronto was honored in entertaining representatives of a free association of men and women voluntarily banded together in the furtherance of life's constructive influences. The Red Cross ideal has power to attract and to hold: it represents the finest type of citizenship in the community, the nation, and the world.

Teaching Human Relations

Classes in human relations provide an opportunity for students from Grades VI to XII to take part in open and unrestrained discussions on matters which are important to them. The discussions are as free from teacher direction as possible. Students can, therefore, express their fears, doubts, joys, grievances, and ambitions. They can explore any problem that is bothering them.

Some doubts have been raised about the advisability of permitting students so much freedom in their discussions, because on some occasions the authority of parents and teachers has been questioned. Professor John R. Seeley, a key person in the project, contends that good mental health implies freedom and autonomy; that good character is evidenced only in free choice, and that democracy means free and responsible citizens.

Some of the results of these classes are:

Students became extremely involved emotionally in the problems they selected for discussion.

The selection of problems was good and students carried on their discussions in a very mature manner.

The experimental group showed gains over the group who had not had human relations classes in being happier, better adjusted, and less withdrawn. They had fewer nervous symptoms and a greater acceptance of their own classmates and other students.

Canadian Association for Adult Education.

The Practical Aspects of Carrying on the Head Nurse Study

C. B. WALKER

We were of the impression in this study that if any single head nurse attempted to set down what she does it would not be accurate or representative of what other head nurses do. When we were looking for an idea of how best to record what the head nurse does, we found an article in *The Canadian Hospital* entitled "Ninety Minutes in the Day of a Busy Head Nurse." I think we would be correct in saying—it records four accident cases admitted in the first 20 minutes—that it perhaps is not quite the typical situation in a ward.

Instead of working from available records we went ahead and set up a working model. In other words, we put together a ward. We decided on the type of cases involved; the number of beds; the number of student nurses and graduate nurses and we even threw in a ward maid for good measure. Then we set our head nurse about her tasks. This was put in the form of a narrative, which was then read out to a trial observer at the approximate speed at which the head nurse would accomplish her tasks.

The result of that was rather interesting. First of all, we found it took nearly as much time to record the time as it did to record what was going on. To overcome this difficulty, we prepared a printed sheet with the time intervals written down the left-hand side, the time series put on the top of the sheet, and the rest of the sheet set for time references. This cut down the time involved in recording somewhat.

It is interesting to consider the size of the time interval we show. In our initial discussions we had ranged through such alternative as "Let's see what she is doing every five minutes" or, as with the Massachusetts' study, record what was going on every minute. Our approach was generally one that we have attempted to follow throughout this study—that is, in any piece of scientific research you attempt to record your data as accurately and precisely, in the terms in which it occurs, as possible. In other words, let your data speak for itself.

Experimenting with our narrative, we found we could write down what was going on in 15-second units of time—i.e., a new line was provided for each 15-second episode of recording. There were 40 units to each page of our records. The need for such fine discrimination in time becomes apparent from the fact that after coding it was found an activity lasted about one-half minute on the average. An activity may be defined as any situation in which the nurse is oriented to any single task without interruption.

The question then arose as to what to record. Here again we let ourselves be guided by our material. We attempted to isolate the intrinsic aspects of the situation without distorting the record in process. A case in point: Supposing we had decided to record all head nurse contacts with her staff by a symbol—"s" for staff; it is obvious then we would have lost the significant differences in time spent with graduates and student nurses, the ward clerk, etc.

A study of the record of our trials made us recognize that there are several distinct features to the nursing situation on the ward. We were not just recording an activity. We were not making a time-and-motion study in the ordinary sense in which industry deals with time and motion, in which you lift your arm and put it down again, involving a certain amount of effort. Recording activities, as was undertaken in this study, focusses our attention on the motivation and direction of behavior as oriented to the job situation. Thus our records deal with activities in the nursing situation,

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Mr. Walker is a staff member of the Research Methods and Analysis Section, research Division, Department of National Health and Welfare.

attempting to specify them as they are seen and understood by the nurse who is carrying them out, rather than attempting merely to observe somebody walking around making motions.

To ensure that our information was complete, we set up our form so as to isolate the various aspects of the situation which we wished to record. By ensuring that there is a separate position to record any aspect of the situation that you wish to measure, you thereby force the observer each time, in recording an activity, to take account of that variable and either indicate its presence—the form in which it is present—or indicate its absence. This technique provides for greater accuracy and flexibility in the analysis and correlation of the various aspects of the situation.

Specifically, on our form, after the column entitled "Time" the next column was entitled "Place," indicating at any time precisely where in the ward the head nurse was working. The next column was entitled "Activity." She was nearly always *doing* something. About 1 per cent of her time the head nurse was in transit between activities; under such circumstances we would indicate only her location. The next column was entitled "Persons"—persons with whom she was in contact. Often there was more than one person with whom the head nurse was in contact and we distinguished between "primary" and "secondary" contacts. For instance, if she was visiting a patient with the doctor but was primarily dealing with the doctor, the patient would be the secondary contact in that situation.

The next column in our form included two aspects of the situation, which we found could complement one another

Time	*Place*	*Activity*	*Person*	*Eqmt. & Procedure*	*Topic of Conversation*
0000	pt. room	asks R.1 tells	pt. 4 stu.		How you? Some better. Give Mrs. E. enema.
0015	W.C. Desk	asks	W.C.		Diet ticket made out?
0030	"	R.1	A. H. Nurse		On diabetic diet. Oh fine.
0045	n.stn.	asks Q.A.	G.N.		Dr. H. phone? No. Want me to get O_2? Yes, 2 tanks.
0100	"	looks up phones		Phone list T	
0115	"	R.1 tells	W.C.	T	Mrs. J. forgot slippers. Take them to admitting.
0130	"	asks	switch	T	Have Dr. H. phone when comes in.
0145	Chart desk	puts away Q.A.	stu.	Chart	Have we filter paper?
0200	H.N. desk	tells	G.N.		Check with Miss X. Dr. H. to call.

very well. They were "Equipment" and "Procedure." We initially had them in separate columns but we found it practicable to combine them. Our definition of a "Procedure" was any typical nursing procedure which might involve several minor activities, such as setting up an intravenous or preparing a hypodermic. We conceived there would be instances in which we would wish to record, apart from the immediate activity—whether measuring something or cutting a piece of rubber tubing—the general orientation of her behavior. We found that very often the mention of the equipment made apparent the procedure or the mention of the procedure made the equipment inevitable, so they become complementary concepts in our study.

Our final column, to which we gave considerable space on the form, was for "Conversation." It was the topic of the conversation that we wanted. We did not attempt to write down, verbatim, every word said in the situation; rather we attempted to summarize the content of the conversation. On the other hand, if the head nurse, when walking down the hall, met a student and said, "Did you find it in the upper left-hand corner?" At that time we would have no idea of what she was talking about, so we would write down, "Did you find it in the upper left-hand corner?" and carry on with her other immediate concerns and then perhaps later either ask her or, from a review of the record, would find out the significance of her comment.

In recording we adopted certain devices which again our material suggested to us. It was not necessary to prepare an exhaustive list of abbreviations because it became quite natural to shorten our recording in certain ways. For instance we would use the initials "D.R." for "Dressing Room;" "M.C." meant "Medicine Cabinet;" "G.N." for "General Staff Nurse;" "W.C." for "Ward Clerk" and so on.

In recording activities, we attempted very little control over the wording except to ensure that we recorded fully what was going on without ambiguity. Certain conventions were adopted by us, such as "Q" and "A" when a question was asked by somebody of the head nurse and she answered it. Certain other simple terms were preferred as taking the least time to record clearly what was going on. Chart work involved considerable use of abbreviations. The symbol "T" in the equipment or procedure column indicated when any contact was made by telephone.

I may say in many instances the conversations were recorded much more completely than I had been able to anticipate and it was not until we sat down and thought about the situation that it became apparent how succinctly they had been recorded. I feel that very little of the essential content of the conversations was missed.

I have thrown together here two minutes of record as a demonstration of the sort of thing we found on the ward. It may be a more crowded two minutes than many. Certainly we all recognize when a nurse is checking linen she is doing one thing for a considerable period of time but if you reckon an average of one-half minute per activity, you can recognize such situations are unusual.

During this two-minute period, she is in five different locations. She has contacts with seven different persons and in some of the 15-second periods there are actually two activities involved rather than one. This is typical of many busy periods of the day.

When it came to trained personnel, we were fortunate that the two observers from the hospital, Mrs. Edgar and Mrs. Thomson, were like ducks taking to water and Mrs. Botsford, our nurse associate, was right back on her old stamping ground. So I struggled manfully to find out how to keep track of a head nurse. About the third nurse I went to see taught me a lesson. I started out with her and, as we were walking down the hall she stopped to discuss something with a student nurse, in the process of which she dropped her keys. I was overcome by the situation and did not know whether I should stoop to get the keys or go on recording, so I tried to do both. I got the keys up all right and noted her discussion and then pursued my head nurse who, by this time, was unlocking the linen room door and at that moment turned around and looked very oddly at me. I suddenly realized I had followed the student—not the head nurse! ! !

Similar but less drastic problems necessitated a trial period during which the business of observing and recording became familiar to all of us. Some of the problems of standardizing recording technique became clear. Some of the minor difficulties in making entries precise were reviewed. We also experimented with the length of observation time. I might say we felt it was as much if not more in the interest of head nurses, rather than the observer, that we made our period one hour for the actual carrying out of the study. The observation period had to be long enough that the head nurse would not be able to say to herself, "Here they come; if I just keep at this a long enough time, they'll go away and I can go on with my work." However, it was not sufficiently a long period that everybody in the ward would be saying to one another, "Don't go near Perkins; she's got her shadow."

Certain general rules were laid down which established uniform procedure in recording. Whenever possible the full period was devoted to the head nurse if she appeared at all. A few records were completed after someone else was in charge of the ward. In an emergency the observer was to stand clear or where the presence of another party might disturb relationships with staff or patients. It was not always necessary for the observer to see what was going on as long as conversation was audible. With regard to overtime we all decided to remain with the nurse during any extra time she might put in. An analysis generally shows that she is concerned with regular ward duties during such periods. Incidentally I should mention that during that trial period we observed a total of 30 hours exclusively on head nurses. This material has not yet been analyzed but it is always available for supplementary study if we have time.

In the coding of the records we were guided by our data as far as possible. Here is where the empirical use of abbreviations stood us in good stead. We went through the records in review to see how many places the nurses had been on location. We found there were up to 19 code numbers that referred to the nursing station area. There were several that referred to what we term "other work areas of the ward," including treatment room, dressing room, utility room, and so on. Patients' quarters constituted another region. There we were able to distinguish between private and public beds. The remaining sections of the code referred to public areas of the ward and other areas adjacent to the ward. On the Persons Code, we listed the abbreviations we had used and our code naturally fell into such areas as: administrative staff; hospital and nursing; school of nursing; various departments of the hospital; maintenance personnel; housekeeping; dietary. Patients and visitors were simple code numbers by themselves.

On the Equipment and Supplies Code we felt there was no need to go into details of equipment. We roughly classed them as administration, medical and nursing, housekeeping and dietary equipment and supplies. The major area of detailed coding here was for hospital forms. Every form that was in use in the hospital was enumerated and classified as a form relating to the administration of patient movement, a record of patient care, a dietary form, a record of drugs and medication, and so on.

For the code of Activities the framework of the code was set up and our problem was largely confined to attempting to fit the code to the material and see how complete and satisfactory it was. It turned out that we were able to extend the code to clarify some of the situations that occurred on the ward and many new activity code numbers were developed consequently. One major problem was to deal with supervision or direction of activity. In these instances the head nurse's involvement was strictly limited to secondary participation in the situation. The more we looked at our task the more it seemed we would have to tackle our activity code all over again. We finally adopted the design of using a suffix "S" for "supervising" and "D" for "directing" in the Activity Code to indicate when the head nurse was involved in supervising or directing an activity, rather than carrying it out herself. Essential to this definition is the notion that supervision and direction do not add anything to the activity except to clarify, expedite, or harness the energies of the person carrying it out.

In coding through to the detailed activity, we can extract whatever details we choose. The code is so constructed that if we analyze to the 100's we get very broad areas of nursing functions as some of our charts will indicate. If we analyze to the 10's we get areas of nursing functions serving several activities; and, if we analyze to the digit, we get specific activities.

It is probably of interest to illustrate the effectiveness of our code breakdown. When the material was all coded and tabulated, we prepared a percentage distribution of time to see how many activities involved more than 1 per cent of the head nurse's time. Only 30 kinds of activity involved more than 1 per cent of her time. In other words, for the remaining 200 or more types of activities, each in itself involved less than 1 per cent.

It is probably of interest to mention some of the most frequent types of activity:

Relating to *patients:* Observation of the patient's general condition, observing specific symptoms of disease, maintaining patient morale.

Relating to *the doctor:* Assisting in planning patient care, giving information regarding the patient, assisting with examinations, accompanying the doctor on rounds, reading orders.

Relating to *staff:* Attending administrative meetings, making out the rotation schedule, maintaining good relationships with and checking on the whereabouts of hospital personnel.

Relating to *patient care:* Preparing and giving day reports, preparing and reviewing the Kardex, planning patient care and discussing patients with members of her staff.

Relating to *drugs:* Checking on the administration and counting of drugs, making out medicine cards, medicine requisitions, and preparing work for the blood team.

Relating to *housekeeping:* Securing, tidying, and distributing equipment on the ward and maintaining the ward diet list.

Several types of analysis of our data have been undertaken through the way it is set up. There are several variables which we have been able to use for cross-tabulation, whether it be the Location or the Persons Code or Equipment or Supply or the Activity Code. Our data has been analyzed according to ward status—private, semi-private, etc.—type of case—medical, surgical, etc.—and sex of patient. We might also mention the special analysis made of veterans' wards and the children's ward. Analysis has also been carried out according to time of day, nurse status, nurse observed, and observer.

It is also possible to re-group the code items if we so desire. For instance, if we wish to pull out all code numbers relating to diet, each aspect of the situation relating to diet has a separate code number—e.g., writing diet cards, preparing diets, serving trays, advising patient regarding diet, etc. All such individual code items can be re-grouped to carry out special studies, whether to make an analysis of the head nurses' total responsibility for drugs, diet or lanudry.

Through the interrelationships which can be developed between the various codes there is considerable flexibility in making special studies of the data. We can, for instance, correlate the nurses' activity pattern with her contact with persons or with her use of equipment, etc.

It should be recognized that the completion of such an analysis will involve us in considerable future work, especially since all preliminary hand tabulations are to be cross-checked with the punch card counts. It is already apparent in general, however, that the head nurse's participation in the work of her ward is so diverse and intense that some pruning and reorganization of her work is essential if she is to adequately carry out her administrative and supervisory functions effectively.

Be studious in your profession and you will be learned. Be industrious and frugal and you will be rich. Be sober and temperate and you will be healthy. Be in general virtuous and you will be happy. At least you will, by such conduct, stand the best chance for such consequences.—
BENJAMIN FRANKLIN.

Role of the Nurse as Active Participant

MARION BOTSFORD

In May, 1951, I was asked by the C.N.A. Committee on Nursing Care to participate in the study of head nurse activities. At that time I received an outline of the suggested project which included reference to the need for research in the nursing service field and the following statement:

> The over-all problem is to determine the function and relationships of all types of nursing personnel so that nursing care may be improved and nursing personnel utilized in the most economical way.

The reasons for selecting the head nurse for the initial study were stated and the following outline of the suggested study was given:

> *The title:* An Activity Analysis of the Work of the Head Nurse.
>
> *The purpose:*
>
> A. To determine:
>
> 1. What are the present activities of the head nurse?
> 2. How is the head nurse's time distributed among her present activities?
> 3. What part of her time is being spent in non-nursing and non-head-nurse activities?
> 4. Can any of these be done by other personnel?
> 5. What personnel could perform the non-head-nurse duties and what time would this require?
>
> B. As a result of this information, to suggest a re-allocation of functions to achieve greater efficiency.

With this outline in mind, during the summer months the draft report of the study of head nurse activities conducted at the Massachusetts General Hospital was studied and other background reading done.

When I arrived in Ottawa on September 1, I was not at all sure what my duties would be as a participant in the study. I had been designated as a "research assistant" in the draft plan. Having been an assistant for some years, this term was familiar and comforting but the term "research" was rather awe-inspiring. However, I was convinced that this was another forward step for Canadian nursing and that it would be just a beginning in an expanding program of research in the field of nursing service.

My first few days were spent in becoming familiar with the facilities and personnel at the Ottawa Civic Hospital. The cooperation of the hospital board in permitting me to stay in the residence was very much appreciated. This made it possible for me to become familiar with the various members of the staff which was helpful as the study progressed. It was my feeling throughout that the nurse participant should avoid becoming identified too closely with any one group, such as the administrative staff, the instructors, head nurses or staff nurses. It was felt, too, that it was essential that no reports of performance or information of a confidential nature should be carried from one group to another by the participants in the study.

On September 4, I reported to the Research Division of the Department of National Health and Welfare where I found that Mr. Josie and Mr. Walker had already done considerable preparation for the study. In fact they were quite familiar with the activities of the head nurse as she appears in a textbook. Several draft forms for use in recording had been prepared and some practice in the recording of activities had begun. The latter was done by one member of the Division reading an account of the activities of a fictitious head nurse while another member endeavored to record the activity on the draft forms. I shall not soon forget my first experience of being given a stop-watch and an activity record form, marked off in 15-second

Mrs. Botsford, who is assistant registrar with the Registered Nurses' Association of British Columbia, had considerable experience in an earlier research project in Manitoba.

intervals, and listening to an account of the activity of a busy head nurse with a view to recording such activity in an accurate and meaningful manner. Such experimentation led to the compilation of a relatively small list of descriptive terms which could be used uniformly by all observers under the various headings on the activity record form.

As work progressed the duties of the nurse participant developed along three lines:

1. As a liaison between the research division and the hospital.
2. As a technical consultant.
3. As a research assistant.

Liaison

As liaison between the Division and the hospital, statistical data and other material concerning the Ottawa Civic Hospital was gathered as required by the director of the study. Annual reports were obtained from the superintendent, blueprints of the hospital wards from the chief engineer, and a great deal of very valuable material concerning the nursing department was made readily available by the director of nursing whose interest in keeping accurate and comprehensive records was very evident. Manuals of administrative procedures, of record forms, and of job descriptions were available and Miss Young gave freely of her time (both on and off duty) to discuss matters pertaining to the study. These included the selection of head nurses to be observed; the selection of two suitable nurses to act as observers; arrangements for practice observations and the instruction of the nurse observers; the orientation and preparation of the head nurses for the study; and many other details. Her enthusiastic cooperation at all times was most helpful.

As it was essential that the understanding cooperation of each head nurse, as well as the other members of the hospital staff, be obtained if the study was to be successful, every effort was made to interpret our aims and objectives and to avoid misunderstanding on the part of those concerned. Considerable orientation was done at a regular staff meeting where Mr. Josie, Mr. Walker and I were permitted to speak on the plans for the head nurse study. I outlined some of the reasons why research was felt to be needed in the nursing service field and briefly referred to the over-all research program of the C.N.A.

The reasons for choosing to observe the head nurse as a beginning in the study of nursing functions were outlined, as well as the reason for selecting the Ottawa Civic Hospital. The purposes of the study, as outlined in the directive from the C.N.A., were given and the head nurses were asked to cooperate in making the study as accurate as possible. It was explained that their activities would be timed by an observer at various times of the day, that our wish was to disrupt as little as possible the routine of the ward, and that we would appreciate an attempt on the part of the head nurse to carry out her work as if the observer were not present. We asked also, however, that when it was obvious that we could not obtain the meaning of a situation without her assistance—for example, when she answered the telephone—we would appreciate a few words of explanation in order to make the situation meaningful. It was stressed that the purpose of the observer was not to evaluate performance or to criticize the work of the head nurse.

Outlines of ward routines were studied and the nurse participant visited each head nurse selected for study in order to ascertain how the routine was adjusted to meet the needs of each particular ward. This information was required for the preparation of observation time-tables. These personal visits also offered an opportunity to familiarize the head nurses with the objectives of the study, to answer individual questions concerning it, and to reaffirm that it was not the function of the observers to criticize or to report observations to the hospital administration.

Technical Consultant

My duties here were to interpret to the members of the Research Division, when necessary, technical terms and procedures used in the hospital. I should like to think, too, that I was able to give at least some interpretation of the broader aspects of the nursing profession during our discussions.

RESEARCH ASSISTANT

The major portion of my time was spent on duties which could be classed as those of research assistant. Prior to carrying out actual observations it was necessary to learn to use a stop-watch and to record activity on the forms prepared for this purpose. This was first practised in the office. Various activity records were experimented with and revised to facilitate rapid and accurate recording. Later practice periods were arranged and carried out in the hospital for varying lengths of time at different times of day.

In cooperation with Mr. Walker two additional nurse observers were taught the recording technique which had been developed. Practice periods were arranged for them following which their records were reviewed and discussed in a group conference. We felt that we were very fortunate in the selection of the two nurse observers. One was a former supervisor who was well accepted by the head nurses and the other a newcomer to the staff who was at that time in charge of the nurse aide program and had had broad preparation and experience. The accuracy of their recording technique developed rapidly.

In order to assist in the preparation of the schedule for the final observations the weekly timetables of the head nurses' hours were obtained through the cooperation of the nursing office.

During the two-week official observation period 30 one-hour observations were recorded by each of the four observers. As soon as possible after each observation period the records were edited. This was necessary because, as you can imagine, it is difficult to write legibly while running down a corridor after a busy head nurse or when, as sometimes occurred, she carried on more than one activity within a 15-second interval. Mr. Walker and I edited our own records and were each responsible for reviewing the records of one of the other observers and discussing with her any points which were not clear in order that the meaning of each item would be correctly interpreted when the time came to code the records.

I also assisted in the preparation and use of the supplementary records concerned with the time spent by the head nurses on telephone calls and administrative forms and those concerned with persons and places. I prepared diagrams of the arrangement of the nursing stations on the various wards.

After the observations were recorded the matter of coding the material became the chief concern. Some work was done experimentally with the code prepared as a result of the Massachusetts study. After considerable study and discussion it became apparent to the members of the research team that a code must be built up to meet our own needs. The over-all plan for the code was drafted by the director of the study and was revised as necessary when the research assistants studied the activity records in relation to the code outline.

It was a great disappointment to me that my three months had expired before the actual coding could begin as I felt that I could have been of considerable assistance in interpreting many of the items recorded. This does not mean, however, that I have any doubt concerning the accuracy and wisdom of my coworker's coding. I should have liked very much to have been able to follow through with the project to its completion.

In conclusion may I say that it was a privilege to be associated with the members of the Research Division and to gain some insight into research methods and techniques. I feel that nurses will need the assistance of such experts for some time yet. However, I hope that a manual will be prepared as a result of this study and that further research projects will be carried on in the nursing service field.

I should like to express my sincere appreciation to the C.N.A. and to the Research Division of the Department of National Health and Welfare for affording me the opportunity to participate in this interesting project.

A man's body and his mind, with uttermost reverence to both I speak it, are exactly like a jerkin and a jerkin's lining: rumple the one, you rumple the other.

—LAURENCE STERNE

The Impact on the Hospital

EDITH YOUNG

It was with interest but also with apprehension that the nursing director of the Ottawa Civic Hospital awaited the arrival of the research personnel for the study of the head nurse activities of our hospital. Interest because of the vital part played by the head nurse in the nursing service set-up and of the knowledge that her job does need analysis. Apprehension not only at the thought of all our diagnosed as well as our undiagnosed imperfections being brought into focus under the C.N.A. microscope but also because of the effect the actual study might have on the already overburdened head nurse.

My first fears were allayed with the arrival of Mrs. Botsford, who almost at once identified herself as a member of the research team. It was a privilege to know and work with them.

It was a revelation to me, unaccustomed as I am to research, to realize that before a study such as this was initiated it was necessary almost to pry open the cornerstone of the hospital in order that the workers would have a complete picture of the institution—past and present.

As has been pointed out, various tools were used:

> Blueprints of the physical aspects of the ward; annual reports of the hospital; personnel cards of staff; policy books, form books, procedure books; lists of duties of nursing office staffs—supervisory, head nurse, ward aide, ward clerk; manuals of information for nursing staff, ward clerks, and ward aides; even a folder containing handwritten statements of duties performed by the employees in one department, which had lain dormant awaiting action by the director of nursing, was utilized.

Following this introductory orientation of Mrs. Botsford, the remaining members of the research team were introduced to the superintendent of the hospital and the director of nursing. At this time information about the research plan and procedures, as well as hospital policy and routines, were discussed with me. I might add here the non-nursing research personnel had a great deal of knowledge of hospital nursing service.

To appreciate the feelings which the head nurses might experience while being observed, I was shadowed by a team member for a short period. I am certainly not normally tongue-tied but it was found to be somewhat difficult to carry on an interview even of minor importance with one of the staff members in the presence of the research worker. This gave me much more understanding of the effect the study might have on the head nurse.

During the preceding month, both nursing supervisor observers and head nurses had the opportunity to become familiar with the novel methods of research workers. At the regular monthly staff meeting, all non-hospital personnel on the research team were introduced to the hospital nursing staff and the purpose as well as the general methods of procedure of the study were interpreted to the group.

In this month, also, the observers were coached in their roles and had several practice sessions with the participating head nurses. Great interest in this procedure was shown by other nursing staff members, physicians, interns, and auxiliary staffs. This afforded an excellent opportunity for the observers to talk about the Canadian Nurses' Association and its relationship to the profession of nursing. The nurses in general were stimulated in the realization that personnel outside the profession were actually interested in nursing and in the specific duties of the head nurse.

The initial reaction of the head nurses themselves seemed to be one of trepidation and occasional resentment. They feared that such close observation of their activities was a method of checking on their performance as head nurses. Such, of course, was not the purpose of the survey and this was readily made clear to them.

Miss Young is director of nursing at the Ottawa Civic Hospital.

Prior to the four weeks of planned concentrated observation, the head nurses were informed that there would be eight hours of observation for each one of them and that they would not be notified in advance. A few of the staff members were disturbed that they would not be warned. However, they soon adjusted to the sight of an observer appearing at odd hours for another session.

In preparation for this panel, a questionnaire was sent out by the nursing administration to each head nurse. Each was asked to give "the effects of the survey as you realized it." This was answered anonymously by a group of the head nurses who were observed. These answers have been listed under two arbitrary headings—e.g., favorable and unfavorable.

UNFAVORABLE COMMENTS

"Things could not be carried on normally, as the students did not feel free to ask questions regarding treatment, etc."

"It was annoying to have to repeat all telephone conversations."

"There was an atmosphere of strain during the period of observation and, as a result, the head nurse did not always do the things she would normally do—that is, activities which required considerable concentration or explanations to members of her staff."

"At all times, every head nurse, no matter how intelligent or well adjusted she may be, is under a terrific nervous strain. Having someone follow continuously at her heels and make notes of every word uttered simply added to the already overburdened mind."

FAVORABLE COMMENTS

"At first I was nervous about being watched but gradually found that the survey personnel were very unobtrusive."

"We had very little upset in the ward routine due to their presence."

"I was interested in the effect on patients but, in no instance, was there an objection."

"Actually this survey had a stimulating effect on administration and nursing personnel."

"This survey did not affect my department organization at all but I am sure it will surprise the general public to find out the responsibilities carried by the head nurse and how well these are accomplished."

"After the first day, all resentment vanished and I became very interested."

"I am sure this project made the head nurses take stock occasionally and wonder if what they were doing at some moments could not have been done just as well by a nonprofessional worker."

"It would seem that this survey should publicize the Ottawa Civic Hospital beneficially."

COMMENTS OF THE SUPERVISOR OBSERVERS

It was felt that at least 60 per cent of the head nurses were much busier while the observer was there than they are normally.

At the beginning of the observation period a few head nurses expressed their nervousness and one was openly resentful. However, after a few practice sessions most head nurses were more relaxed and carried on their activities in the normal way. As stated previously, all staff members cooperated after interpretation of the purposes of the study had been given. The supervisor observers were grateful to the research team for explaining their methods and goals so well.

The supervisor observers felt that being in uniform helped to make them more anonymous to the patients and to other staff.

Considerable interest in the research method was expressed by one intern, a few seemed to treat it as a joke, while the majority were extremely interested in the actual project.

Only one occasion was met in which a doctor questioned the observer's presence but he, too, was most cooperative after the survey had been explained to him. One physician stated: "I could do this analysis as well as a whole raft of outsiders." However, on the whole, they considered this analysis "a good idea."

A great deal of time was spent by

the supervisor observers in interpreting the purpose and reasons for this survey.

It was felt that this survey caused the head nurses to think more objectively about the particular activities which they perform. The comment was frequently made by the head nurses that they felt they had too much paper work to do and that more of it could be done by a nonprofessional worker than is now carried out by ward clerks. This was also believed to be true by the supervisor observers.

CONCLUSIONS

The impact of such a research project was extremely beneficial to the hospital in that it stimulated all participants to think more about their specific activities. It was informative in that the nursing staff gained considerable insight into research methods.

It was rather amazing how little disruption, if any, there was to the normal functioning of the ward.

This experiment will add to greater interest in, and greater appreciation of, other research studies initiated by our association.

It is realized that much greater benefit will result when the findings of this study are made available to every professional nurse.

It is my personal hope that this is just the beginning of a series of analyses of nursing service personnel and that the Ottawa Civic Hospital may have the privilege of being a partner in further research studies of nursing service and, I might add, of nursing education.

A Nursing Registry

Editor's Note: Last spring, Mrs. W. S. Pickup, a member of the board of the Thunder Bay Community Nursing Registry, was interviewed over Radio Station CFPA, Port Arthur, Ont., regarding the objectives, activities, and general development of this important community program. The verbatim conversation is reported here in the hope that some other nursing registries in Canada may be able to work out a similar project with their local radio station.

Question: What do you want to talk about today?

Answer: The annual report and financial statement of the Nurses' Registry has just come to hand and, because it is a community organization, I would like to tell you about it. We are accustomed to refer to this organization as the Nurses' Registry but the official name is "Thunder Bay Community Nursing Registry." In the 10 years since its inception in 1942 it has been enlarged to serve more groups than nurses.

Question: That sounds interesting from a community point of view. Who is in charge and how is it staffed?

Answer: Miss Margaret Flanagan is the registrar and all who work with her are Registered Nurses. All have a special training for this service. There are in the office three full-time and one relief worker. This is not an isolated registry as it is sponsored and guided by the Registered Nurses' Association of Ontario. There are 25 in Ontario, all working under the same constitution, bylaws, and regulations, although the Board of Directors has a local autonomy.

Question: What is the purpose of this organization?

Answer: Primarily, it is to secure quicker, efficient service of doctors and nurses when need arises. Few people realize that one call to the Registry will bring them nurse, doctor, ambulance, arrangement for hospital bed, etc. The registered nurse in charge is fully trained and is competent to give first-aid advice by telephone to serve until the doctor arrives. In fact, one call to the Registry can bring almost a dozen services.

Question: You spoke of doctors and nurses. Can you tell us about those who are on this Registry?

Answer: Registered nurses who are

not employed by institutions and hospitals and who wish to do special, full-time or part-time nursing. Last year there were 48 of these. There are four practical nurses and nurses' assistants registered as well as doctors who wish to have their Sunday, holiday, or evening calls answered when no one is in the office. You will find in the telephone book, listed under doctors' names, "When office doesn't answer call Registry." Some have direct lines from office and home. The V.O.N. is also on the Registry, thus saving an office girl. In other words, a V.O.N. nurse need not stay in the office when she could be spending her valuable time at her professional work.

Question: How is this financed? Service like this must cost a lot of money.

Answer: You will be surprised when I tell you how little this Registry costs the community. In fact it is run on a shoestring:

1. First—there are fees from doctors, nurses, and all who use the Registry service.
2. Two small grants are received from the hospitals, who often telephone for emergent help.
3. Two small grants from the cities.
4. Small alumnae grants.
5. And, lastly, one tag-day a year is held in Fort William and one in Port Arthur. The total amount received last year was $5,635. There was a small surplus to carry on this year till receipts began to come in again. It is one of the very most efficient bits of bookkeeping of which I know.

Question: Is there a record of all calls received by the Registry?

Answer: Even that is detailed in this annual report. It has been estimated that one incoming call for a doctor necessitates five outgoing calls; for a nurse—four. Doctors are more difficult to locate evenings and holidays than are nurses and the total number of calls handled last year was over 96,000. On Boxing Day, which was supposed to be a holiday, incoming calls were 196, outgoing about 800. Illness is no respecter of holidays. When the Registry had been organized for four years, the record showed the number of calls was 21,526. Is it any wonder they require a much larger switchboard which will be installed shortly?

Question: Since those who register are fully qualified, I suppose there is no special training needed.

Answer: You are wrong there. Special instruction is given by the registrar who has taken courses in this very thing. Classes include:

1. Educational programs.
2. Counselling.
3. A provincial institute is held annually for Registry personnel. Due to the cost of travel, and so forth, only one nurse can go from here each year. Careful attention is paid to find suitable nurses or nurses' assistants for the patients with whom they work, thus eliminating square pegs in round holes.

Question: You spoke at the beginning of a Board of Directors. Will you outline their duties?

Answer: The Board of Directors is composed of 26 members, elected from every hospital and nursing service at the Lakehead. It also includes representatives from the V.O.N., Welfare, the Medical Association, and one member from the community at large. The standing committees are: Registry Advisory, Credentials (evaluation of applicants), Publicity, and Educational. A good Board makes for efficiency in operation and planning. You just can't do today's business with yesterday's tools if you want to be in business tomorrow.

Question: This seems to be a very efficient service. Is there anything that could be added regarding plans for expansion?

Answer: Yes. The services now undertaken are well organized and one or two more are under consideration—namely, home-helpers and baby-sitters' services. There is need in the community for both of these if set up efficiently. One completely new service, inaugurated this year, was registering 280 nurses for the Civil Defence course. It is anticipated that the Registry will play an important part in Civil Defence as the need develops. One item discussed at the annual meeting was "shared nursing," which is nursing of two patients. This is almost a new idea here which could be of benefit to both patients and nurses under certain conditions.

Fortify yourselves with contentment, for this is an impregnable fortress.—EPICTETUS.

Institutional Nursing

Another Finger in the Dike

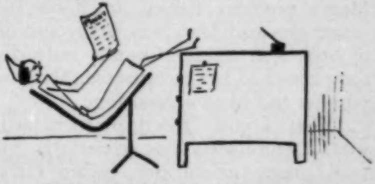
LUCY WILLIS, B.S.

Shortly after eight o'clock, the shrill voice of the telephone demanded my attention. "Please come to the nursing office," was the message. As I stepped out of the residence into the warm air, I almost mechanically noted the clear, blue sky, the soft green of the leaves, and the expectant chirping of a young robin family in the trees across the driveway. I squinted as the bright sunlight struck the crisp white of my uniform. I nodded "Good morning" to a couple of doctors and then stepped into the cool darkness of the hospital.

Once in the office, the routineness of the day came to an abrupt end . . . we were going to experiment! For some time the school staff had been concerned about the students, recognizing that they were not getting enough help with many of their problems. I had worked closer with them than anyone else. Would I like to have time to do something about it—to set up a guidance program? I had been doing what I could, in a meager way. Though I was not qualified for such a task, I realized that even to have time to organize what I had been doing would be an improvement. Innocently enough, I agreed to try, buoyed up by promises of help from other senior staff members.

This was in June, 1947. I had the summer to size up the situation. I enjoyed the prospect of getting to know the students better and decided this should be my starting point. I studied their records for clues of who they were, what they were like, and learned what I could about their homes, schools, and families. I talked to them about themselves, I built up a filing system to keep track of the 200 girls. It became a pleasure, rather than a task, to attend their activities. I liked to think they got to know me better, too, and to see me more as a friend than a "sleuthervisor" as one of them so neatly put it.

There was a fairly active "student government" and with our common interests it was easy for us to work together. Student activities took on a new importance, increasing in number and variety. Sports, dances, socials, and teas were tackled with enthusiasm. A school paper provided for creative expression. In fact, one of my favorite pastimes was reading between the lines, literally, for clues to student problems. Many a truth was innocently revealed in jest.



READING BETWEEN THE LINES

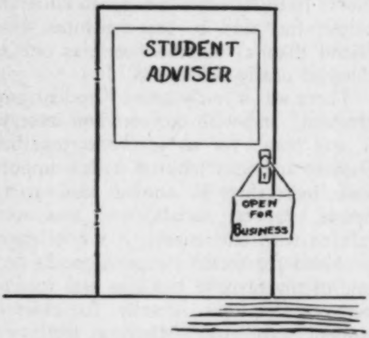
I found it to my advantage to continue to teach a few classes, especially to the new students. They were more at ease in "skills" classes and, as they bandaged and chatted, I was able to see how they got along with their classmates. Allowing free discussion in classes was another way of getting to know them better.

Other members of the teaching and administrative staffs were helpful with observations and suggestions. Some cooperated by working with students who had particular problems. Others gave moral support when it was most needed. A more experienced person in the guidance field could have capitalized on their interest. I struggled along as best I could, making mistakes and correcting them when I had better insight.

When the experiences related here took place, Miss Willis was the educational and social director of the School of Nursing, City Hospital, Saskatoon, Sask.

Housemothers were a source of help. They kept a motherly and sympathetic eye on their charges and often picked up the first sign of unhappiness or trouble.

So I set about organizing my work. I soon found out that organization, as I had known it, was a thing of the past. I threatened to throw out my desk calendar and hang an "open for business" sign on the door. I never knew who was coming in. She might have a question needing only a "yes" or "no" answer or one that would take months or years to solve.



I learned not to jump to conclusions. Mary's problem helped teach me this. Instructors said Mary was sleepy and disinterested in class. Clinical instructors complained of her carelessness. Mary was popular and liked a good time.

"Aha," I said, "too many social activities." Fortunately her classmates provided more information before I took action. Mary had resigned as chairman of the dance committee because she had had a quarrel with her fiancé. She didn't want to go to a dance. She didn't want to do anything! What a different basis for understanding her behavior!

It was not surprising that many of their problems had to do with "boy friends." "Should I accept an invitation to visit my boy friend at an out-of-town college, with only his landlady as chaperon?" "Is the front entrance of the residence private or public property when I want to say goodnight to 'the one and only'?" "How many evenings a week can I spend with Jim while he's at 'U' and I'm here? He's pretty important to me but I don't want to jeopardize my standing here." "The housemother says I'm out too late and too often but I must see Jack as much as I can now. He's going down east and he'll be gone for ages!" "Should I go dancing with a boy I like, if my parents don't approve of it?" "Should I quit training now and get married?" "The boys my group go with are 'fast.' I don't like them but I don't want to be left out either."

DEAR DOROTHY DIX:

Problems existed where they were least expected. Grace, who had a very creditable record at the school, came to a routine student-adviser discussion tense and unhappy. "I'm working as hard as I can. I study a lot. I can't do any better." Her lips trembled and tears threatened. She was constantly comparing her record with that of an older, brilliant sister and thought we were doing the same. She left the office, a much happier girl.

?
To climb, or not to climb?

The student adviser never knows whence her help will come. In my case, it was a skiing accident. With my right arm in a cast I had to call on students for help and they willingly came to my assistance. Teaching became a cooperative effort. But the payoff came the next winter when fun-loving Peg, a student, fractured an ankle when skiing. Stretched out on her bed, her first words to me were "Oh, I'm so glad you hurt yourself skiing last year. No one has said I was foolish to go skiing, or thoughtless, or silly, or anything!" A small thing, perhaps, but important if you are the victim!

QUIET PLEASE

PARTNERS IN CRIME!

There *were* times when I was doubtful. I tried to let the students do the deciding when they were the parties most concerned. Thus, when Jane came to me at the end of a preliminary term with a very poor record behind her, I thought she should make up her own mind to leave. She had had great difficulty adjusting to the school and her studies had suffered accordingly. She could not go on. I had no doubt that she would decide to leave but I left the decision up to her. Imagine my consternation when she weighed the problem and decided that, with my permission, she would start over again. Reluctantly I agreed, as I had given her the choice. Jane surprised us all and, at the end of a totally satisfactory preliminary term, with a crisp, new cap on her head, she burst into the office to say "thank you." "I don't know myself anymore. I'm a different person. And I'm so happy!" I assured her she had only herself to thank and, as I looked at her happy young face and felt the glow of her new-found personality, I knew my own satisfaction was as great as hers.

Soon they began coming of their own accord with their troubles and we worked on them together. They surprised me with the maturity of their judgment. Almost, without exception, students who had an opportunity to prove themselves did so. Together we abolished the old late-leave system and urged individual students to make their own decisions in this matter. As a group they came through with flying colors.

Sometimes I felt like a mother whose child had learned to get along by himself before she was willing to let him go. This was true about a tea for prospective students. I suggested it as a possible project to the student association. Before I knew it the plans were complete—date decided, committees picked, publicity taken care of and, although I was kept well informed on developments, there was nothing for me to do. Fortunately I kept my peace and the tea was a huge success.

The eagerness with which these students accepted what little we had to offer suggests that this is a neglected area in schools of nursing. If you do not have some such program, I suggest you think seriously about it. You could do a great deal with what you have. Few schools can afford a full-time, qualified guidance director but there are other resources in your community. Is there a university that would help you, within reasonable distance? Many high school teachers, Y.W.C.A. and church workers have had special preparation in guidance. Perhaps one of them would work with your staff, organizing, helping them improve their skills and techniques. Together you can learn how to listen efficiently, to recognize significant behavior, to establish rapport. You might study the older adolescent, then evaluate your school. Are you providing for the usual activities of young people through which they achieve normal development? You will need to provide for students who have problems requiring highly skilled counselling. Here again you may have to depend on the community for part-time or consultant services.

Every student should have access to the type of guidance she needs. Nursing schools, like other schools, have a responsibility to the student to help her on the way toward realizing her full potentialities. Are we justified in operating schools that do not fulfil this—*the primary task of education?*

Public Health Nursing

What Should Tommy Eat?

DONNA M. BAXTER, M.SC.

The newer knowledge of nutrition, based on the results of hundreds of research projects, is beginning to provide us with a clear and concise answer to the question "What should Tommy eat?" Those actively engaged in health work are becoming increasingly aware of the importance of the food he eats to Tommy's physical and mental well-being. If Tommy is to be well nourished, it is necessary that the food that he eats every day, year in and year out, shall contain all the essential nutrients in abundance and also that this food shall be well digested and absorbed and shall be carried to the tissues in all parts of his body.

Since good nutrition is impossible unless food furnishes an adequate amount of each of the essential food factors, the Canadian Council of Nutrition, which serves in an advisory capacity to the Minister of National Health and Welfare, has approved a new dietary standard for Canada.[1] This standard is based on the opinions of the most reliable authorities on the subject and recommends amounts of calories, protein, calcium, iron, vitamin A, thiamin, riboflavin, niacin, ascorbic acid, and vitamin D, which individuals of various body sizes need each day.

To provide a basis for selection of foods to meet the daily needs, as listed in the dietary standard, a simplified guide, Canada's Food Rules, was adopted by the Canadian Council of Nutrition in 1944. Canada's Food Rules, as shown below, are based on servings from five major food groups—milk, fruit, vegetables, cereals and bread, and meat—plus a source of vitamin D. The term "serving" used in the Rules gives ample leeway to provide for widely divergent needs according to age, sex, size, and degree of activity. Each of these food groups contains a wide variety but, whatever combination of foods is chosen for a day's menu, it should include servings from each of these groups. Any group omitted may be a very serious handicap to growth and health:

CANADA'S FOOD RULES

These foods are good to eat.
Eat them every day for health.
Have at least three meals each day.

1. *Milk*

   Children (up to about 12 years) at least 1 pint
   Adolescents ......at least 1½ pints
   Adults ....at least ½ pint

2. *Fruit*

   One serving of citrus fruit or tomatoes or their juices; and one serving of other fruit.

3. *Vegetables*

   At least one serving of potatoes; and at least two servings of other vegetables, preferably leafy, green or yellow and frequently raw.

4. *Cereals and Bread*

   One serving of whole-grain cereal; and at least four slices of bread (with butter or fortified margarine).

5. *Meat and Fish*

   One serving of meat, fish, poultry, or meat alternates such as dried beans, eggs and cheese.

   Use *liver* frequently. In addition: *eggs* and *cheese* at least three times a week each.

   Vitamin D—At least 400 International Units daily for all growing persons, and expectant and nursing mothers.

Approved by the Canadian Council on Nutrition, 1950 — Nutrition Division, Department of National Health and Welfare, Ottawa.

Miss Baxter is assistant to the director, Health and Welfare Education, Manitoba Department of Health and Public Welfare, Winnipeg.

For the purposes of this paper it will be considered that Tommy is a five-year-old boy. A comparison will be made between his needs, as listed in the dietary standard, and the amounts of the essential nutrients provided by the food groups listed in Canada's Food Rules. This comparison will prove that Canada's Food Rules are an excellent basis for feeding Tommy, that a mother cannot go wrong using the Rules as a foundation for her menu-planning. Each food group contributes to the total of essential nutrients and it will be found that all of Tommy's requirements are met with the exception of calories and calcium. Extra servings of the basic foods, with some sugars and starches, make up the extra calories and three-fourths of a cup of milk will make up the extra calcium.

The following foods have been chosen for this comparison:

Milk group:
- 1 pint whole milk

Fruit group:
- ½ small orange
- ¼ cup applesauce

Vegetable group:
- 1 small potato
- ¼ cup beets
- ¼ cup green beans

Cereal and Bread group:
- ½ cup rolled oats
- 3 slices bread
- ½ ounce butter or margarine

Meat or alternate group:
- 2 ounces ground beef
- 3/7 egg
- 1/7 ounce cheese

Vitamin D group:
- 400 International Units

The average size of servings for a five-year-old child has been used. As you can see, these are quite ordinary foods that might appear on the average table. None were chosen for exceptionally high nutrient content.

The Table of Food Values Recommended for Use in Canada$_2$ was used to obtain the nutrient value of each of the foods listed. Results have been tabulated and are shown in *Table I*. From *Table I* percentage figures were calculated and these are shown in *Table II*. An examination of this table will show how important is the contribution of each group in the over-all total:

GROUP I

Milk — Milk contributes more to Tommy's diet than any other single food. It is outstanding as a source of calcium, riboflavin, protein, thiamin, and vitamin A. Although sufficient quantities of thiamin and vitamin A may be furnished in other foods, it is almost impossible and very expensive to furnish Tommy with adequate calcium, protein, and riboflavin without milk.

One pint of whole milk provides 70% of Tommy's calcium requirement. It is to be noted that the other food groups provide relatively little of this mineral. Some vegetables are quite good sources of calcium but could not begin to replace milk. If Tommy's milk consumption is raised by ¾ cup, bringing it up to 3¼ cups, 100% of the calcium requirement will be met. For calcium safety, then, Tommy should have 3½ to 4 cups of milk daily. More than 4 cups of milk is not necessary as an excess of milk may easily crowd out other foods.

One pint of whole milk contributes 126% of the riboflavin requirement. The meat group is the only other fair source of this vitamin. Without milk only 43% of Tommy's requirement is met. As this vitamin, riboflavin, is extremely sensitive to light much of it may be lost by leaving the morning milk on the doorstep in the sun.

Milk is also a good source of the best quality protein, contributing 52% of Tommy's daily requirement. Without milk it would be necessary to get that protein from meat or eggs, which are generally more expensive per gram of protein.

Skim milk contains as much protein, calcium, and riboflavin as whole milk. When whole milk is skimmed, calories are reduced and all of the vitamin A is removed. Tommy's vitamin A requirement can be well covered without milk—that is, with extra margarine or butter or green and yellow vegetables—and it is possible for him to make up the lost calories with other foods. So skim milk may be used in place of whole milk when economy is necessary, as skim milk may be purchased at a little over half the cost of whole milk. The use of skim milk may mean the difference between Tommy having insufficient milk and getting enough milk to meet his daily needs.

TABLE I

COMPARISON OF DIETARY NEEDS OF A 40-LB. (5-YEAR-OLD) BOY WITH AMOUNTS OF NUTRIENTS*
SUPPLIED BY FOODS LISTED IN CANADA'S FOOD RULES

FOODS AND AMOUNTS	*Calories*	*Protein*	*Calcium*	*Iron*	*Vit. A*	*Thiamin*	*Riboflavin*	*Niacin*	*Vit. C*	*Vit. D*
Milk, whole—1 pint	381	20.6	.696	.6	945	.23	1.005	.6	6	..
Orange, ½ small (⅛ lb.)	18	.36	.013	.16	77	.032	.012	.09	20	..
Applesauce—¼ c. (2 oz.)	29	.15	.003	.15	45	.02	.015	.1	5	..
Total FRUIT GROUP	47	.51	.016	.31	122	.052	.027	.19	25	..
Potato—1 small (2 oz.)	47	1.1	.006	.4	11	.06	.03	.7	6	..
Beets—¼ c.	22	.57	.009	.4	12	.007	.012	.07	3	..
Green beans—¼ c.	13	.63	.017	.88	258	.02	.025	.2	2	..
Total VEGETABLE GROUP	82	2.3	.032	1.68	281	.087	.067	.97	11	..
Rolled oats—½ c. (⅔ oz.)	68	2.4	.008	.8	..	.12	.03	.1	..	..
Bread, white—3 slices	240	7.5	.027	.6	..	.06	.06	1.2	..	..
Butter—½ oz. (on bread)	108	.1	.003	..	500	..	..	..	..	..
Total CEREALS & BREAD GROUP	416	10.0	.038	1.4	500	.18	.09	1.3	..	..
Ground beef—2 oz.	104	11.06	.006	1.65	..	.045	.096	2.7	..	..
Egg (average 3/week)	31	2.4	.01	.51	219	.017	.055	..	..	..
Cheese—1/7 oz. (1 oz./week)	15	.94	.027	.04	53	.001	.017	..	..	..
Total MEAT GROUP	150	14.4	.043	2.2	272	.063	.168	2.7	..	..
Vitamin D—400 I.U.	..	..	..	..	..	..	..	..	..	400 I.U.
Total SUPPLIED BY C.F.R.	1,076	47.81g.	.825g.	6.19mg.	2,120 I.U.	0.612mg.	1.357mg.	5.76mg.	42mg.	400 I.U.
5-YEAR-OLD (40 LB.) NEEDS**	1,600	40g.	1.0g.	6.0mg.	1,300 I.U.	0.5mg.	0.8mg.	5.0mg.	30mg.	400 I.U.

*Figures taken from "Table of Food Values Recommended for Use in Canada," published by Nutrition Division, Department of National Health and Welfare, Ottawa.

**Figures taken from the "Canadian Dietary Standard."

TABLE II

A Percentage Comparison of Total Nutrients Supplied by Food Groups Shown in *Table I* With the Dietary Needs of a 40-lb. (5-year-old) Boy

		Calories	*Protein*	*Calcium*	*Iron*	*Vit. A*	*Thiamin*	*Riboflavin*	*Niacin*	*Vit. C*	*Vit. D*
Milk Group	Total	381	20.6	.696	.6	945	.23	1.005	.6	6	..
	%	24	52	70	10	73	46	125	12	20	0
Fruit Group	Total	47	.51	.016	.31	122	.052	.027	.19	25	..
	%	3	1	2	5	9	10	3	4	83	0
Vegetable Group	Total	82	2.3	.032	1.68	281	.087	.067	.97	11	..
	%	5	6	3	28	22	17	8	19	37	0
Cereals and Bread Group	Total	416	10.0	.038	1.4	500	.18	.09	1.3	..	..
	%	26	25	4	23	38	36	11	26	0	0
Meat Group	Total	150	14.4	.043	2.2	272	.063	.168	2.7	..	..
	%	9	36	4	37	21	13	21	54	0	0
Vitamin D	Total	..	..	..	..	..	..	..	..	..	400 I.U.
	%	0	0	0	0	0	0	0	0	0	100
Total OF FOOD GROUPS		1,076	47.81g.	.825g.	6.19mg.	2,120 I.U.	0.612mg.	1.357mg.	5.76mg.	42mg.	400 I.U.
Total PERCENTAGES		67	120	83	103	163	122	169	115	140	100
5-YEAR-OLD (40 LB.)		100%–1,600	40g.	1.0g.	6mg.	1,300 I.U.	0.5mg.	0.8mg.	5.0mg.	30mg.	400 I.U.

GROUP II

Fruit—The most outstanding contribution of this group is vitamin C or ascorbic acid. This vitamin is found in large quantities in citrus fruits. One half of a small orange provides 20 mg. of ascorbic acid and this represents 66⅔% of Tommy's total requirements. With ¼ cup of applesauce contributing 16⅔%, the total contribution for the fruit group is 83%. One half orange daily can, therefore, be considered an ample serving for five-year-old Tommy, if he is also being given sufficient vegetables. It can easily be seen that without one excellent source of ascorbic acid in the diet, it would be impossible to reach the 100% mark. Tomatoes, raw, cooked or canned, tomato juice, or raw cabbage are also excellent sources of ascorbic acid and can be used in place of citrus fruit occasionally. Since ascorbic acid is not stored by the body, a daily source of this vitamin is a necessity. Fruits are also important in Tommy's diet for their roughage value.

GROUP III

Vegetables — Vegetables are important chiefly for iron, vitamin A, and vitamin C. One small potato, ¼ cup of beets and ¼ cup of green beans contribute 28% of the iron, 22% of the vitamin A, and 37% of the vitamin C requirements. The vitamin A contribution is very important. Vitamin A is found in abundance in dark green and yellow vegetables and these should be included in Tommy's diet often.

Vegetables make a significant contribution of vitamin C. If properly cooked, potato can contribute about 6 mg. daily to the diet. Because vitamin C is destroyed rather quickly by oxygen and by heat, the vegetable group should not be counted a too reliable source of this vitamin.

Fruits and vegetables, because of a similarity in vitamin and mineral content, can be used interchangeably to some extent. If Tommy wishes to eat a second serving of fruit and not eat his vegetable, no harm will be done. However, this does not apply to citrus fruits, as Tommy eats so few other foods that contain large quantities of vitamin C.

GROUP IV

Cereals and bread—Cereals and bread are important items in Tommy's diet because of their energy value, protein, iron, and thiamin. One half cup of rolled oats and 3 slices of bread with butter or fortified margarine provide 26% of the calories, 25% of the protein, 23% of the iron, and 36% of the thiamin. The 38% vitamin A contribution is from the butter included in this group. A whole-grain, home-cooked type of cereal was chosen because its cost is less for the food value received and ready-to-eat cereals may or may not contain the whole grain.

Apart from the milk, the rolled oats is the largest single contributor of thiamin. Without this serving the thiamin intake is dangerously close to the minimum. If the milk consumption is low at the same time, it is very difficult for Tommy to obtain sufficient thiamin.

Although this group is not the largest contributor of protein, still it is to be noted that without this group the protein intake would fall below 100%.

GROUP V

Meat and alternates—This group is most important for its 36% protein and 37% iron. Abundant growth will take place more satisfactorily if Tommy eats an ample supply of protein. This group will supply 36% of his requirements. Without sufficient meat or alternates, protein intake falls too low. If milk, which supplies 52% of the protein, is also lacking or taken in insufficient quantity, there may be protein undernutrition. When protein is low, iron is often low, too, and anemia may result from lack of sufficient iron. The meat group supplies 37% of Tommy's iron requirement.

Although milk and meat are both high-quality proteins, they cannot be used interchangeably. Meat does not contain sufficient quantities of calcium and milk is low in iron. An adequate amount of each must be included in Tommy's diet—that is, three to four cups daily of milk and at least two ounces of meat or alternates daily.

The inclusion of liver once a week, as suggested in Canada's Food Rules, would considerably increase the percentages for vitamin A, iron, and the B vitamins, as this food is an extremely good source. This serving of liver would be insurance against insufficient intake.

Eggs and cheese, both high-quality proteins, are also included in this group. Eggs also contribute significant quantities of iron, vitamin A, and riboflavin. If possible, an egg a day should be included in Tommy's diet.

VITAMIN D

The dietary standard calls for 400 Int. Units of vitamin D daily for Tommy. As this vitamin cannot be obtained in the usual foods, some other source must be used. Any form of Vitamin D, a synthetic form or a fish-liver oil authorized by Tommy's physician, would be suitable. Direct sunshine falling on the skin forms vitamin D in the body but in this country the months of available sunshine are short and this cannot be counted as a reliable source of vitamin D. Care should be taken not to give Tommy an overdose of this vitamin as it may be dangerous and it is most certainly wasteful and expensive.

EXTRA FOOD

So far there has been little mention of calories. Canada's Food Rules will provide Tommy with only 67% of his need. They were never intended to be used as a maximum food intake but rather as a nucleus for menu-planning, a list of protective foods which could provide the user with the assurance that he or she was eating well and that all the essential needs would be met. Tommy will no doubt wish to eat extra foods over and above those used in this comparison. It is better, though, that he be given more of the basic foods rather than sweet, fatty, or starchy foods. One cup of milk, one peanut butter sandwich, and one banana will provide Tommy with those extra calories and at the same time raise the percentages of the other nutrients. These extra nutrients can be called a "margin of safety."

SWEETS

The amount of sugar that is used in sweetening fruits or in simple desserts is all that Tommy needs. The inclusion of sweet desserts, candy, and soft drinks should be delayed as long as possible, as Tommy develops a "sweet tooth" soon enough without being encouraged. Sweets also are thought to be one of the primary causes of tooth decay, both because of their immediate effect on the enamel of the tooth and because they dull the appetite for the foods necessary to make and keep teeth sound.

The same foods that were eaten in early childhood should continue to be the basis of the diet during the school age. The quantities, however, should be increased to take care of the child's greater needs as he grows older. Were a similar comparison to be done between an 11-year-old school child's needs or the needs of an adolescent, and the nutrients provided by the foods listed in Canada's Food Rules, there would be similar percentage results. The only difference would be in the size of servings used.

There is no doubt that we could exist on two or three foods if we knew which ones and how much of each we needed but parents should be encouraged to give the child a variety of foods so that they can be sure that all nutrient needs are well covered. The child's appetite is a good guide as to how much he needs but he must be given a good variety. If Tommy sleeps well, plays with vigor, has a good appetite, and has the general appearance of well-being, parents can consider that he is healthy and that he is eating enough of those foods which he needs.

Canada's Food Rules, shown by this comparison to supply the needed nutrients daily, is our answer to "What should Tommy Eat?"

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A daily feeling of fatigue suggests that a check-up of eating habits is advisable. If the diet is not well balanced, a lack of energy is likely. There may be a lack of iron in the blood, a condition that may be helped by eating beef, liver, kidneys or other foods containing the needed mineral. Dried fruits, such as apricots, raisins, and prunes, are also recommended.

Hospital Daze

JANE POWELL

Editor's Note: Whenever a nurse has to become a patient in a hospital, whether it is the one from which she graduated or another, there is a stirring behind the scenes among the staff members. Reputedly, nurses are supposed to be "difficult" patients to care for. They know what should be done and, in many cases, the staff may be edgy in performing that care.

When the fact that a patient is a nurse is *not* revealed, sometimes some rather dreadful breaches in nursing technique may show up. When they do, what should the graduate nurse do about it? Reveal that she is a nurse and endeavor to help the student to a better appreciation of the patient as a person? Complain to the supervisor or even the director of nursing? Write a letter of criticism to the hospital or perhaps even talk about it to her friends outside of nursing? What would you do?

Our author, using a nom de plume, is an active registered nurse engaged in a branch of public health nursing in a large Canadian city. We publish this article in the hope that everyone who reads it will appreciate and profit by the lesson that lies behind the humor and the jibes. For this kind of careless thoughtlessness and slipshod technique can and does occur. No nurse would tolerate this sort of care for her own mother if she were a patient. Let every nurse determine it will not happen to any patient!

* * *

Do you know what it feels like to be a movie star? Neither do I but after being discharged following a nine-day stay in one of Canada's general hospitals, I imagine my feelings must have been very much akin to Olivia de Havilland's as she emerged from "The Snake Pit."

Nowadays, no one's operation is news—not even a movie star's! But it may be news to some members of the nursing profession to learn that some curious changes seem to have come about in what used to be termed "bedside care."

In the first place, great strides have been made in the matter of the "prep." Who among us does not remember wrestling with a voluminous sheet, struggling to drape the patient so as to expose only the area to be prepared? Remember how quaintly we fan-folded the bedding and with what exaggerated care we substituted a bath blanket? How very time saving is the up-to-date, streamlined technique when, by merely pushing the covers to the foot of the bed and raising the gown to the desired level, the entire area—not just a little piece—is brought to light. But one needs time to adjust to the modern methods. When I modestly enquired about a drape, the nurse looked baffled for a moment but resourcefully rose to the occasion by placing a bath towel and my face towel in strategic positions. It was a happy inspiration as the news-agent chose that moment to call to enquire if I wanted a paper! What I wanted more than anything was one of those large beach umbrellas!

During the "prep" itself, another adjustment was necessary. Three student nurses wandered in to see how their classmate was faring at this, her first "prep," and an orderly, who was using the balcony outside my room, glanced casually in, while I crouched under the quite inadequate protection of the two towels. If you are eccentric, as I seem to be, or prefer a little privacy for this part of your hospital stay, you would be well advised to make yourself a drape before admission and go in with a determination to demonstrate the use of such an article. Too, it might be a sound idea to take along a few printed cards—"Treatment being given"—and a supply of thumbtacks, just in case, for they seemed to be in short supply where I was. Or perhaps the student nurses could not read.

Even more significant changes have taken place in the routine afforded post-operatives. At 7:15 a.m. following my day of surgery, an owlish student nurse came into my room, carrying about one pint of lukewarm water in a basin. This she placed on the bedside table, dunked my washcloth and, placing my towel on the bed, left me to fend for myself with a mumbled, "Guess you can bathe yourself, can't you?" Sodden with demerol and sleep, I managed to stay her departure by suggesting that she remove the bedclothes and spread a bath blanket. I somehow feel she looked upon this suggestion as "unfair to student nurses" and I wondered guiltily if I would be reported to the supervisor as "one of those troublesome cases." Alternately clutching my sutured middle and my buzzing head, I stretched out my hand, dabbled it in the water, sloshed the washcloth over my face and hoped that a merciful death was not too far off.

A few minutes later, the owlish one appeared again, this time actually offering to wash my back. Anxious to overcome the poor impression the bath blanket episode might have created, I agreed eagerly but timidly suggested that we might need to add a little hot water. It was a silly suggestion, we realized at once, because when she explored the basin with a tentative forefinger, she was able to assure me the water was still quite hot. This was surprising—it hadn't been hot ten minutes ago—but possibly it had been quietly generating atomic energy while I was lying thinking up ways to bedevil the overworked nurses. Be that as it may, I was asked to roll over (do not expect to be assisted in that performance; it appears the nurse's job nowadays is to stand and watch the patient struggle, possibly prodding the uncooperative ones with the business end of her bandage scissors!) and my gown was opened as far as the neck. Goose pimples rose in serried ranks as the washcloth trailed over my back. To my mind, at least, the temperature of that particular bath water was a very, very moot point. However, we know that all things in this world are relative. The soap was rinsed off, the towel applied lightly, and a handful of alcohol cascaded down my spine. This was quickly mopped up with the towel and a cloud of talcum descended on my damp skin. Later, it afforded a certain amount of entertainment to pick the caked talcum off those parts of my back within reach. That sort of thing could, I suppose, fall under the heading of "occupational therapy" but it could be embarrassing to explain to visitors.

A cup of mouthwash was presented at the time of the bed bath. (I use the term in its loosest sense.) One cup per day is evidently the ration, so should you have an idiosyncrasy about cleaning your teeth after every meal, don't forget to take your mouthwash with you—it can be wrapped quite easily in your drape. What a waste of time it must have been for us to attend lectures on the need for good oral hygiene if, nowadays, with just one cup of pre-breakfast mouthwash, our modern hospital authorities can proudly boast that not one single case of foot-and-mouth disease has ever broken out among the patients! Perhaps the patients don't stay long enough for the outbreak to mature—who knows?

The once almost sacred "germ theory" appears to be another purely imaginary thing (like the equator) and has apparently gone by the board. In our day, do you remember—thermometers were kept in solution in the patient's room? Not so in 1952, however, for the one that I used was placed in a dry container on my dresser and I must admit that I seemed none the worse for it. Think of the financial saving in thermometer solution! If all hospitals are observing the same technique, they should soon be out of the dire financial straits we have been hearing about for so long. It is, as any economist would point out, the little things that mount up.

If you were taught to warm a bedpan before offering it to a patient, believe me, you were wasting a lot of time during your training period. Only once did my shrinking flesh feel a grateful warmth. The up-to-date routine is to shove an ice-cold pan under one's quivering buttocks and then abandon the patient to her fate. How you may manage to lurch and heave yourself into an upright position is purely your own problem and you can solve it any way you like. But it does bring up another point. Along with the drape, the mouthwash, and the printed cards, tuck about six feet of stout hemp rope in your bag. You can fasten one end to the foot of the bed and a strong pull on the other end will put you where you want to be, as it were, in time.

By now your suitcase will be bulging

but do try to squeeze in a couple of clean sheets. Notoriously, all hospitals are chronically short of linen. In my case, one certain sheet stayed with me for seven days, doing duty as top sheet, bottom sheet and, finally, draw sheet. I've often wondered what happened to it when they did at last take it away. If the linen situation is that acute for private patients' rooms, the mind reels at the hideous possibilities that exist for the unfortunates in public wards.

Perhaps my experiences may have been unusual. I hope so. But comparing notes with a friend who recently underwent a Cesarean section, I find that her treatment followed closely along the same lines. It may be that these changes are the professional manifestations of progress and, because we live in an age of antibiotics, early ambulation and the cobalt bomb, we must be willing, as it were, to give and take. It could be, too, that the rugged treatment handed out to patients nowadays is strengthening their characters. In my mind, it is undoubtedly contributing to the shorter hospital stay.

One thing puzzles me. If student nurses never put into practice the "nursing" techniques taught in the classroom, why is it necessary to continue the training period for three years? By eliminating all or most of the "nursing" part of the course, nurses could be graduated after a few months—even weeks—of intensive lectures in those subjects termed essential. Here, it seems to me, is a solution to the whole question of the nursing shortage. Or do I hear a spirited defence from an outraged group of instructors?

In the Good Old Days

(The Canadian Nurse—DECEMBER 1912)

"Thousands of churches observed October 27th as *Tuberculosis Day*. Organizations that are fighting the tuberculosis plague selected this particular day as one on which special efforts should be made to arouse public interest in the prevention of the disease. Prominent clergymen agreed to bring to the attention of their congregations the question of the prevention of consumption and to suggest ways and means by which church-goers may cooperate in the national campaign against the scourge. It was planned that emphasis be laid upon the growing evil of the use of fraudulent remedies for the cure of tuberculosis."

* * *

"Royal Alexandra Hospital, Edmonton, established twelve years ago, has now grown to have a staff of eight graduate nurses. There are 44 pupil nurses who receive training in medical, surgical, and obstetrical nursing."

* * *

". . . a little human contact with the sick . . . develops in any true nurse the more worthy love of service. And . . . it feels surpassingly more satisfactory to her to give a child a nice, warm bath, than it would to be present at an operation where the honored appendix of the Duke of Somebody is removed."

* * *

A nurse is a practical woman. Heroics make good telling. Patient, persevering, sane, intelligent nursing helps to save life and gives comfort to the patient and a heart full of gratification and satisfaction to a nurse, though nothing worthy of limelight be produced."

The problem of population is certainly one of the most challenging within the area of interest of The Rockefeller Foundation and should receive the support of the Foundation on the broad front of health, agriculture, education, the social sciences and humanistic studies. All of these must work together if the patterns of population growth are to be identified and scientific means for the direction and control of growth are to be discovered and applied. It was felt that although a program of this kind would require a long period of careful development, and that the costs would be considerable, a beginning could be made within the existing sphere of operations of The Rockefeller Foundation.

Aux Infirmières Canadiennes-Françaises

Un Aspect du Nursing Industriel

ALBERTINE MAILLOUX

(Suite de l'édition de novembre)

Le Comité de Sécurité dépend encore de l'importance d'une industrie. Mais dans les grandes comme dans les petites usines l'infirmière joue un grand rôle dans la prévention des accidents. Il y a différentes manières d'organiser la sécurité. Notre Comité de Sécurité se compose:

1. De la direction.
2. D'un comité central, comprenant l'ingénieur du plan, le surintendant, le gérant du personnel, et l'infirmière.
3. Au second plan se rattache le comité de l'usine (atelier), représenté d'un côté par deux représentants de la compagnie, de l'autre côté par deux représentants de l'union des ouvriers et, enfin, au centre l'infirmière.

Vous voyez que l'infirmière fait partie des deux comités—c'est qu'elle doit collaborer avec la direction et avec les ouvriers. Les membres du comité de l'usine font l'inspection du moulin une fois par mois et une copie de l'enquête est remise à chacun des membres des deux sections, tant du comité central que du comité de l'usine. Entre temps les employés peuvent faire des suggestions qui sont prises en considération au cours de l'assemblée mensuelle du comité. Toutefois si une suggestion présente un intérêt pressant, elle est étudiée immédiatement.

Si, pour une raison quelconque, les membres qui inspectent ne s'entendent pas sur un point, une assemblée spéciale est convoquée à laquelle prennent part les membres du comité central et du comité de l'usine. Pour compléter, chaque chef de département est membre de la sécurité et doit, quand il lui est possible, accompagner les membres du comité de l'usine chaque fois qu'il y a inspection dans son propre département.

En vous détaillant ce Comité de Sécurité, je n'ai pas la prétention de la considérer comme irréprochable. Les industries de même catégorie peuvent instituer un comité beaucoup plus élaboré. Mais il s'en trouve aussi où le travail de prévention est moindre. J'ai voulu simplement donner une idée du fonctionnement d'un Comité de Sécurité pour mieux noter les problèmes qui s'y relient. D'ailleurs, dussé-je aspirer à un programme plus entier, plus perfectionné, mille embûches pourraient m'en barrer la route. C'est un problème qu'il faut admettre.

En effet, nous savons toutes que malgré sa généreuse contribution, l'infirmière ne peut dicter seule un programme de prévention, que d'elle seule ne dépend ni le succès, ni l'insuccès. C'est un travail d'équipe où l'infirmière connaît tantôt la satisfaction, tantôt le contretemps, selon qu'elle reçoit ou non la collaboration nécessaire, car un système de prévention est effectif quand il est appliqué sur toute la ligne — c'est-à-dire, les machines suffisamment protégées, les outils en bon ordre, et l'entraînement adéquat des ouvriers. Il est évident qu'à une telle organisation adhérent une multitude de problèmes dont l'inspection en embrasse une grande partie.

Nous avons toutes une idée de l'inspection qui doit être faite et que les membres de la sécurité doivent s'efforcer de corriger. Une liste de recommandations à ce sujet rafraîchirait notre mémoire mais le temps alloué ne nous permet pas ces détails. Néanmoins, afin de dénicher nos problèmes, citons quelques exemples et constatons combien d'obstacles viennent à l'encontre des idées émises au cours d'une inspection:

Mlle Mailloux est infirmière industrielle à St. Jérôme, Qué.

1. Une garde protectrice est-elle défectueuse qu'on objectera à sa réparation immédiate, la pénurie de main d'oeuvre ou encore le manque de temps disponible?
2. Conseille-t-on d'utiliser une garde protectrice mise au rancart qu'on en accusera sa nuisance dans la course au boni que vise tout ouvrier?
3. Si l'on veut éviter l'encombrement des départements, l'obstruction des allées, le manque d'espace sera invoqué.
4. Les moteurs, les scies, les roues d'engrenage doivent être munis de gardes protectrices. Nonobstant le danger de les enlever pour le nettoyage, le huilage ou le graissage, combien de fois avons-nous entendu des ouvriers nous dire que ces protections les empêchaient d'atteindre les interstices et que l'arrêt des machines en cette circonstance gênait l'opération?
5. Le port du "masque" ou des "lunettes de protection" est parfois prescrit mais il incommodera l'ouvrier qui s'en débarrassera à tout propos.
6. On tentera souvent d'excuser un éclairage insuffisant en alléguant le gaspillage de l'électricité.
7. Aux conditions anti-hygiéniques dans les salles de bain, les ouvriers seront accusés de négligence, de malpropreté. S'appuyant sur ces faits, certains directeurs passeront outre à la suggestion d'augmenter le personnel assigné à l'entretien des chambres.
8. Les ascenseurs monte-charge, destinés à la marchandise, sont interdits au personel, vu leur construction fragile, mais il arrive souvent que des personnes s'aventurent à y prendre place sous prétexte qu'elles sont fatiguées.
9. Généralement les réparations à effectuer en vue d'éliminer les dangers d'accidents sont lentes. Elles sont retardées par ce besoin constant de produire vite, condition caractéristique de l'industrie moderne.

Vous avez reconnu dans cette énumération des faits qui vous sont familiers et je suis certaine que vous pourriez, comme moi, donner des preuves d'accidents survenus dans cette chaîne de risques et de périls qui encercle les ouvriers. Ces accidents démontrent clairement l'obligation d'appliquer des moyens de prévention et point n'est nécessaire de spécifier davantage le devoir de les faire observer.

En dépit de cette action bienséante, l'infirmière apercevra une foule de problèmes. Quand survient un accident l'infirmière doit s'empresser de voir au blessé. Elle juge s'il y a lieu de le référer au médecin ou de faire venir le médecin sur les lieux. Elle se renseigne sur la manière dont l'accident est survenu et donne les conseils de sécurité d'usage. S'il y a nécessité, elle fait enquête sur la scène de l'accident en compagnie du contremaître et s'il s'agit d'un accident plus sérieux elle doit être accompagnée des membres du Comité de Sécurité.

ACCIDENTS DU TRAVAIL

Nous savons qu'il existe des lois provinciales qui prévoient des indemnités pour cause d'incapacité et des traitements médicaux en cas de blessures résultant d'un accident du travail ou d'une maladie professionnelle prévue par la loi. Cette loi prévoit la nomination (par le lieutenant gouverneur en conseil) d'une commission chargée d'appliquer la loi. Cette commission à seule juridiction sur tout ce dont la loi dispose, ce qui comprend: (a) montant à payer; (b) l'indemnité; (c) paiement des frais médicaux; (d) l'établissement de tarifs de cotisation appropriés à chaque classe, car l'industrie doit répondre d'une partie de la perte subie par suité d'accidents du travail.

Cette législation donne de grands avantages à l'ouvrier et adoucit le poids des responsabilités de l'infirmière. Par elle-même, cette loi ne présente pas de problèmes. Au contraire, elle aplanit bien des situations difficiles. Dans son exécution, si nous furetons dans nos pensées il s'en dégagera quelques problèmes plutôt moraux, en se sens qu'un accident de travail déplaît à tout le monde:

1. A la direction qui voit s'augmenter le tarif de cotisation.
2. A l'infirmière qui se dévoue tant pour éliminer les causes d'accidents et qui en un instant découvre une brèche à son organisation préventive.
3. A l'ouvrier qui en plus de souffrir n'aura qu'une partie de son salaire pour boucler son budget.

Parfois l'infirmière aura l'impression qu'un faux rapport est fait ou, qu'au contraire, une compensation est refusée injustement à un ouvrier. Dans ces circonstances particulières, l'infirmière court le risque d'être partiale si son attitude est trop catégorique. Une version claire de l'accident, sans commentaires superflus, atténueront les ennuis.

L'emploi des femmes présente des problèmes de santé mais tout comme l'homme la femme travaille parce qu'elle doit gagner sa vie. L'infirmière doit donc chercher à améliorer son sort. La femme mariée comme la célibataire travaille habituellement au soin du ménage avant et après sa journée à l'usine et c'est pourquoi l'usure se fait rapidement sentir. L'infirmière doit s'efforcer de comprendre ses réactions et de la diriger à temps vers le médecin.

L'infirmière aura aussi à faire face à des cas particulièrement tristes ou ses conseils seront requis—par exemple, des malades lui diront leurs troubles conjugaux, croyant trouver un remède dans l'épanchement de leurs douleurs morales. Ou, encore, une jeune ville viendra avouer un mal qu'elle n'ose dire qu'à voix basse. Il sera alors du devoir de l'infirmière de la diriger à temps vers un lieu de sécurité où elle recevra les soins médicaux appropriés.

Il y a mille causes qui se présenteront autant de problèmes qu'il faudra résoudre. L'infirmière doit être suffisamment renseignée pour apporter un peu de lumière et beaucoup de compassion.

RELATIONS

Les relations de l'infirmière avec les employés et leurs organisations sont importantes au point de vue de sa contribution au programme de santé. Il va sans dire qu'elle devra encore affronter plusieurs problèmes.

L'infirmière doit coopérer avec la direction de l'usine; en même temps elle ne doit pas oublier que l'ouvrier ou l'ouvrière a droit à son attention. Elle reçoit les confidences de tout le personnel et doit posséder un bon jugement pour comprendre l'état émotif d'un père de famille aussi bien que d'une jeune personne qui vient lui demander conseil. Elle doit cependant savoir discerner les sentiments justes et ne pas se fier aux apparences. Il arrive souvent qu'un employé se présente avec une histoire triste à faire pleurer, alors qu'il n'y a qu'un prétexte pour prendre congé.

Il faut que l'infirmière soit consciencieuse vis-à-vis de son employeur qu'elle soit honnête en aidant à la discipline.

L'infirmière peut prendre part aux organisations des employés tout "en évitant de faire partie d'un organisme qui puisse la porter à faire des distinctions contre quelque groupe d'employés." * L'infirmière doit garder une neutralité absolue, comprende que les employés et la direction ne peuvent fonctionner séparément, que les activités doivent converger vers un même but—l'entente cordiale.

Ses droits et responsabilités sont bien définis: Elle a le devoir de travailler dans l'intérêt de ses patrons tout en sauvegardant la santé des ouvriers, respectant les droits de ceux-ci comme de ceux-là.

Mais l'infirmière a tout avantage de participer aux manifestations ouvrières, moyennant cette neutralité. Pour ma part, cette expérience me fut profitable. Dès le début, j'ai encouragé les sports et j'ai fait partie de toutes les équipes organisées, formant une association sportive dont je fus présidente durant toutes ces années. J'ai trouvé là le meilleur moyen de connaître les ouvriers, de les comprendre, de les aider moralement et physiquement, facilitant ainsi l'entente avec la direction. L'an dernier, alors que je décidai de me retirer de l'association, à cause de mes activités trop nombreuses ailleurs, les autorités de la compagnie me prièrent de demeurer dans l'organisation, de continuer d'aider le mouvement et de former les jeunes. De plus actuellement, un plan a été tracé pour ajouter des loisirs à cette association sportive.

Les industriels comprennent donc l'importance des relations sociales dans la lutte contre cette névrose qui envahit le milieu ouvrier, est la source de maladies de toutes sortes, cause tant d'absences, trouble et diminue le rendement, fait de l'ouvrier un insatisfait de la vie.

PROBLÈMES

Mais tous ne réagissent pas de la même façon à ces moyens de détente mis à leur disposition; tous n'ont pas la même aptitude à affronter les problèmes. En

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* *Revue de l'Hygiène Industrielle,* Oct. 1950, p. 24.

dépit de ces compensations, l'industrie, avec son développement intense et rapide, apporte des complications à la vie antérieurement calme de l'ouvrier.

C'est donc à l'infirmière de s'efforcer de maintenir l'équilibre mental qui aide à déterminer l'efficacité du travail. Son influence doit être discrète. Elle ne doit pas s'attarder aux conversations inutiles qui conduiraient vite aux abus, à une perte de temps au détriment de son employeur et multiplieraient ses problèmes. Elle a le devoir de relever le moral non en ruminant les agitations et les désordres mais en cherchant à améliorer les conditions sociales, en encourageant la participation aux saines distractions, et en faisant aimer le travail.

Comme nous voyons, l'infirmière industrielle rencontre au cours de sa carrière de graves problèmes de santé. Si, en apparence, sa vie est facile, personne ne peut nier sa situation perplexe. Il y a dans l'industrie un grand pourcentage de travailleurs enclins à la dépression nerveuse, résultant de la tension continue, d'une personnalité mal adoptée à l'ambiance, des restrictions imposées au budget familial, et de l'insuffisance de la vie sociale.

En faisant ressortir les problèmes les plus saillants concernant le travail de l'infirmière industrielle, nous avons vu un rapprochement de ce que nous avons appris à l'hôpital mais sous un aspect différent où dominent les relations humaines. Cette constatation nous amène à imaginer facilement qu'aux problèmes de santé et d'administration s'ajoutent ceux de l'individualité de l'infirmière dont le plus prominent est celui de sentir le besoin d'être à la fois: infirmière, aide sociale, femme d'affaires.

Il est certes, bien difficile de trouver une formule capable de trancher ces questions épineuses. Le temps aplanira graduellement nos obstacles grâce aux dirigeantes dévouées de L'Association Bilingue des Infirmières Industrielles, dont nous sommes membres, à nos médecins, à la collaboration de nos industriels et de nos gouvernements. Mais avant tout l'infirmière doit apporter sa dot personnelle de coopération sans laquelle l'organisation resterait fragile. Je n'ai pas besoin de rappeler notre devoir à chacune en face de l'intérêt collectif, ni de redire que là se fusionne, se confond notre intérêt personnel. Un moyen de maintenir cet organisme, qui a été institué pour nous protéger, est de reconnaître que l'existence parallèle de nos deux groupes (anglais et français) est une source d'amélioration et de succès. Pour vivre en harmonie, la connaissance des deux langues est une nécessité, donc un problème pour plusieurs d'entre nous.

Nous avons l'obligation morale de donner à notre mouvement, non pas un sens fictif mais tout ce qu'il faut pour le faire vivre jusqu'aux limites de la province. Cette réalisation ne sera pas possible sans que nous mettions, dans cette action, un intérêt vivant. Sans notre participation entière, sans nos énergies, cette statue magnifique reposera toujours sur un pied d'argile or, pendant qu'elle est jeune, donnons lui un cerveau, des membres solides, un visage, une figure esthétique pour qu'on ne dise plus: "Cette infirmière est en nursing industriel? Elle pourrait trouver mieux!"

En marchant vers notre idéal, la puissance médiatrice de l'infirmière est, à mon avis, sa personnalité—personnalité acquise par une culture générale. Plusieurs d'entre nous ne peuvent pas suivre des cours de spécialisation proprement dits mais rien ne nous empêche de perfectionner nos connaissances par des lectures appropriées, faites d'une façon sérieuse et sage, capables de nous inculquer des notions fructueuses et constructives. Et même un cours de spécialisation ne suffit pas si nous laissons par la suite dormir nos facultés.

Nous sommes entrées, il est vrai, dans première des catégories. Le développement intense de la connaissance du nursing nous porte à la spécialisation mais, en exagérant cette expression, l'infirmière est limitée dans ses recherches par les limites mêmes de sa culture. Son attention se fixe sur un ensemble de fractions qui ne l'intéresse ou elle ne retient que le sujet dans lequel elle est formée.

Reconnaissant que les relations humaines dominent dans le vaste champ d'action de l'infirmière industrielle, celle-ci ne doit pas se contenter de connaître la section du nursing où elle déploie ses activitiés. Bien que liée à son groupe particulier sous la même effigie,

l'infirmière industrielle doit élargir son champ de connaissance et collaborer à son avancement professionnel par sa participation aux activités des autres sections du nursing, car son idéal est le même. Si l'infirmière industrielle n'est pas au chevet du malade elle est penchée sur l'humanité laborieuse pour adoucir ses fatigues physiques et morales. Si l'infirmière industrielle est dans le monde des affaires elle est aussi au service d'une société boiteuse et malade.

Considérant ses rapports avec diverses personnalités, diverses associations humanitaires, l'infirmière industrielle doit ouvrir son esprit à tous les domaines. Elle doit développer son sens social puisqu'elle doit collaborer dans différents degrés de l'échelle sociale. Pour être en mesure de comprendre les événements, elle doit avoir une idée de ce qui se fait autour d'elle.

En cultivant sa personnalité, l'infirmière industrielle parviendra à s'assurer d'une vie sociale féconde qui l'éclairera dans sa voie encore abstraite et l'aidera à traverser ses étapes difficiles.

En terminant, j'exprime l'espoir que par une individualité consciente au sein de notre association, nous puissions atténuer nos multiples problèmes, en attendant un remède plus scientifique par l'adoption d'un plan de sécurite sociale adéquat.

The Significance of Interpersonal Relationships

SIDNEY BERENGARTEN

The ability to relate well to other people is important in all vocations or professions but it assumes increased importance in the helping or healing professions. The more we realize the significance of these basic emotional needs, for which satisfaction is essential to our ability to function as mature, self-dependent, and responsible individuals, the more we are convinced that the helping-and-healing-profession person must be able to meet these fundamental needs in others.

Have we selected a helping or healing profession because in our own personal lives we have been given so much recognition and love that it would be a natural extension of our reciprocal emotional investment in other people, particularly those who need to be sustained emotionally or physically? Or do we select such a profession because our pattern has been to be "the obedient good child," by constantly complying and conforming with parental expectations, usually of perfectionistic and uncompromising parents? This meant that we had to repress and bury our hostility while growing up. Outwardly such a person behaves at complete variance with his feelings underneath as a defence against recognizing his hostility. Thus, in selecting a career, one would be considered a "good" person by parents and community, if he prepared for a profession that involves service to others.

It is axiomatic that if we haven't received love we cannot give love. Unless we have had enough positive affectional experiences in growing up from some source, and unless we have had enough affection to compensate for negative experiences within our own families, there is a resulting pattern of lack of trust of other people, of withdrawal, or repression in order to deny our socially unacceptable feelings of hostility. In admitting students to a school of nursing, the important factor to learn about each candidate should be—*How much love has this person received?*

Those of us who have responsibility as educators must try to determine the depth and degree to which the potential student in the helping profession can "give of herself" to other people. "Giving of ourselves" means being *warm, permissive, sustaining, accepting and understanding.*

Reprinted from *The American Journal of Nursing,* October, 1952, issue.

You cannot inherit happiness as you do houses, stocks and bonds, and bank books. You must make it. Create it. It is the only thing on earth that can be increased by dividing it. You may decrease your sorrows by sharing them with someone but the moment you share your happiness with others, you increase it.

Trends in Nursing

Biennial—1954

Speaking of trends, the hope of the C.N.A. is that all its members are beginning to make plans to attend the 1954 biennial meeting at Banff. From preliminary negotiations which have been made, the indications are that this convention will provide those attending with a professional experience and a holiday beyond parallel. The committee concerned with planning the program is eager that the membership-at-large should make known their wishes concerning the program. The provincial associations have all been canvassed for suggestions but the committee is anxious to have still more ideas. What have you to suggest?

I.C.N.—1953

National Office has received a considerable number of enquiries about plans for the I.C.N. in Rio de Janeiro in July, 1953. At time of writing (October) the official application forms have not been received from London but no doubt will be in the hands of those interested when this column is being read. Many important international nursing issues will be considered which should be of great interest to Canadian nurses.

Nursing Leaders

In the October issue of *The Modern Hospital* a most thought-provoking article appeared—"There's no Short Cut to Nursing Leadership," by Everett Johnson, administrator, Chicago Memorial Hospital. Its content is not new to nursing administrators but seems to put into words what many nurses have been practising over the years. It points up the rapidly developing problem of the professional nurse as leader of the nursing team. No longer does the new graduate work on her own for a year or two, responsible only for bedside care to her patients. Now, even as a student, she must be capable of directing the activities of several categories of workers—junior students, aides, maids, and others. Upon graduation she is often precipitated into a charge position because her services are at such a premium and because she, presumably, has had some leadership experience as a student. However, she has not been trained in management and sometimes ends up without the confidence of her staff. On the other hand, she may have the ability to lead but has not a sufficient background of experience. The author also mentions the misinterpretation of "democratic action" where staff members may not understand cooperative agreement and insist on a unanimous opinion before action may be taken, to the detriment of management in general.

The writer states that the development of adequate nursing leadership is hampered by three general policies recommended by national nursing organizations: the traditional emphasis placed on the importance of technical skills; the failure of national nursing groups to promote establishment of a nursing curriculum designed to develop those administrative skills of perspective and balance; and the promotion of the idea that intellectual ability is the most important quality in actual leadership. We probably do not agree with all of the writer's reasons for this statement but they make very stimulating reading.

Discussing skills desirable in a nurse leader, he lists as most important: the ability to arrive at a decision which can be put into operation; then a sense of responsibility; and, third, the proper use of personality.

In conclusion, his suggestion for a solution of the present problem is that nursing educators must realize that emphasis on technical proficiency must not remain the primary objective of the curriculum but should take second place to classes and practice in ward management in the final year of the student's nursing education.

Along the same lines but with the emphasis on the philosophy and use of the nursing team is an article entitled "Good Patient Care and the Team Concept," written by Olga C. Benderoff, associate professor of nursing, Frances Payne Bolton School of Nursing, Cleveland, in *Hospital Progress* (September, 1952).

The Demonstration School

As you will have read in the November, 1952, issue of *The Canadian Nurse,* the Demonstration School at Windsor has completed its four years of operation. In the gathering for the final graduation ceremony a feeling of sadness could be detected. Something special had gone out of existence. A small group of graduates, alumnae of the C.N.A., are left to exemplify the results of an education in nursing planned by Canada's nursing leaders. They are the nurses about whom a report has been written, a report which will be studied eagerly by nursing educators in all parts of the world. It seems rather a heavy burden for such young people but they will not evade their responsibility.

Article on C.N.A. President

Those nurses who receive the mimeographed copies of newsclippings will be able to read an article printed in the *Toronto Daily Star* about our president—Helen G. McArthur. It is an excellent article and shows the increasing attention given by the newspapers and their readers to nursing.

Australian Visitor

During October, National Office had a most interesting visitor in the person of Miss Florence Peterson, principal, Division of Nursing, Commonwealth Department of Health, Australia. She is in Canada on a fellowship from WHO and is particularly interested in professional nursing and auxiliary nursing education. We hope that nursing in Canada came up to her expectations and that she will feel that her time here has been well spent. We, in Canada, are fortunate that our nursing programs are considered sufficiently advanced that we draw international visitors. No great number of us get to Europe, to Australia, or to other continents, and we would miss much of interest outside of Canada if it were not for our visitors from afar.

Rockefeller Foundation Grant to T.C.

The Rockefeller Foundation has made a grant of $100,000 to the Division of Nursing Education at Teachers College, Columbia University, for a five-year study of nursing service and nursing education problems in the U.S. Its first major work will be to consider the need for improving and increasing nursing service in all activities involving nursing.

Harper Hospital Curriculum

In the light of other comments in this column, both in this issue and previous ones, it is of interest to hear that Harper Hospital, Detroit, is planning to change its curriculum on the basis of the results of its two-year curriculum study and of the increasing emphasis on the need for the nurse to be able to supervise and teach. Formal instruction and experience necessary to meet the minimum requirements for registration will be completed in 119 weeks. The remaining period will stress how to work with people and to supervise and teach other nursing personnel.

Season's Greetings

The staff at National Office would like to wish all the members of the C.N.A. full enjoyment of the *Christmas Season* and a satisfactory and *Happy New Year!*

Mealtime should be a pleasant relaxed period, free from arguments with the children as to whether they should or should not eat food they don't like. When Junior refuses some item he doesn't want, it is wise to take him at his word and treat the matter casually. He will probably have forgotten his dislike by the next time it is served, especially if no issue is made of his rejection.

Orientation et Tendances en Nursing

CONGRÈS BIENNAL—1954

Non, il n'y a pas d'erreur de date! L'Association des Infirmières Canadiennes espère déjà que ces membres préparent des plans afin d'assister au congrès de Banff. Les démarches préliminaires indiquent que le congrès offrira, à celles qu'y s'y rendront, une expérience professionnelle et des vacances au delà de toute estimation. Le comité en charge de la préparation du programme veut connaître les désirs des membres en général concernant le programme. L'on a demandé aux associations provinciales de faire des suggestions mais le comité désire en plus connaître vos idées. Qu'avez-vous à suggérer?

LE CONSEIL INTERNATIONAL DES INFIRMIÈRES—1953

Le Secrétariat National a reçu de nombreuses demandes de renseignements à propos du congrès de C.I.I. de Rio-de-Janeiro en juillet 1953. Au moment d'écrire ce communiqué (octobre), les formules d'inscriptions nous ne sont pas parvenues de Londres mais, sans doutes, elles seront déjà entre les mains des personnes intéressées au moment où vous lirez ces lignes. Bien des points d'un intérêt international seront considérés durant le congrès et de nature à intéresser les infirmières canadiennes.

CHEF DE FILE EN NURSING

Dans le numéro d'octobre du *Modern Hospital* un article intitulé "Impossible de Prendre un Raccourci pour Parvenir à la Tête du Nursing" porte à la réflexion. L'auteur, Everett Johnson, est administrateur du Chicago Memorial Hospital. Cet article ne contient rien qui ne soit déjà connu des infirmières s'occupant de l'administration mais il semble avoir trouvé les mots pour décrire la situation où se trouvent les infirmières depuis des années.

Il fait remarquer les problèmes concernant l'infirmière professionnelle, problèmes se développant rapidement dans son rôle de chef d'équipe. Désormais l'infirmière ne travaille plus à son compte durant un an ou deux, avec la seule responsabilité des soins à donner à ses malades. Maintenant, même encore étudiante, elle doit être capable de diriger les activités de plusieurs catégories du personnel infirmier—élèves des premières années du cours, aides, filles de salles et autres. A peine diplômée, elle est déjà lancée comme femme de charge parce que ses services sont en grande demande et aussi probablement du fait qu elle a eu comme étudiante une expérience dans la direction du personnel. Toutefois elle ne connaît rien dans l'administration et souvent elle n'a pas la confiance de son personnel. Si elle a l'habileté de conduire il lui manque ces quelques années d'expérience indispensable. L'auteur mentionne aussi la mésinterprétation du terme "acte démocratique." Souvent les membres du personnel ne comprennent pas ce qu'est une entente collective et insiste sur l'unanimité de l'opinion avant de poser un acte et c'est au détriment de l administration en général.

L'auteur écrit que le développement des qualités requises pour administrer chez les infirmières est gêné par la ligne de conduite recommandée par ces organisations nationales sur les trois points suivants—l'insistance traditionnelle attachée à habileté technique; le défaut des organisations nationales d'infirmières de produire un programme d'étude ayant pour but le développement de l'habileté administrative et un sens d'équilibre, permettant de voir les choses sur leur vrai jour, et de promouvoir l'idée que l'habileté intellectuelle est la première qualité dans l'art de conduire.

Sans approuver entièrement toutes les raisons données par l'auteur pour une telle affirmation, la lecture de cet article nous a fait réfléchir.

Discutant les qualités de l'infirmière à un poste de commande, il enumère comme les plus importantes: l'habileté à arriver à une décision pouvant être exécutée; le sens de la responsabilité; et, en troisième lieu, savoir se servir de la personnalité de chacune.

Pour conclure, il suggère aux éducateurs en nursing comme solution à ce problème actuel, de réaliser qu'une habileté technique ne doit pas demeurer le but primordial du programme d'étude mais doit arriver en second après les classes et la pratique dans l'administration d'une salle de malade, lesquelles doivent être données durant la dernière année du cours.

Un article de *l'Hospital Progress* (septembre 1952), intitulé "Good Patient Care and the Team Concept," abonde dans le même sens.

L'ECOLE DE DEMONSTRATION

Dans *The Canadian Nurse* (novembre 1952) vous avez lu que l'école de démonstration de

Windsor vient de fermer ses portes après quatre ans d'existence. Dans la réunion finale, lors de la collation des diplômes, il y avait un sentiment de tristesse. C'était la fin d'une expérience. Un petit groupe de diplômées de l'Association des Infirmières Canadiennes seront les témoins d'une formation en nursing tel que conçue par les dirigeantes de la profession au Canada. A propos de ces infirmières un rapport a été écrit, lequel sera étudié par toutes les éducatrices en nursing, de toutes les parties du monde. Elles portent une lourde responsabilité qu'elle accepte avec fierté.

UN ARTICLE SUR LA PRÉSIDENTE DE L'A.I.C.

Un journal, le *Toronto Daily*, consacrait un article à notre présidente—Mlle Helen G. McArthur. La presse a reproduit cet article dans les grands quotidiens. Vous l'avez vu sans doute et lu avec plaisir, notant l'intérêt manifesté par les journaux envers notre profession.

UNE VISITEUSE DES ANTIPODES

En octobre dernier, le Secrétariat National recevait la visite de Mlle Florence Peterson, du Ministère de la Santé d'Australie. Cette infirmière est en voyage d'étude au Canada à titre de boursière de l'O.M.S. Elle s'intéresse tout particulièrement à la formation du personnel infirmier.

Il nous fait plaisir de recevoir des visiteurs de l'étranger. Il nous semble alors que nous avons quelques choses à offrir et que nos programmes doivent avoir une certaine valeur puisque de nombreux visiteurs internationaux sont venus les observer.

LA FONDATION ROCKEFELLER

La Division du Nursing de Teachers College, Université de Colombia, a reçu un octroi de $100,000, afin de poursuivre des recherches sur les problèmes de l'enseignement du nursing aux Etats-Unis. Leur premier travail d'importance sera de trouver les moyens pour améliorer et augmenter les services du nursing.

LE PROGRAMME D'ETUDE DU HARPER HOSPITAL

Déjà dans cette colonne nous avons parlé de l'étude poursuivie par le Harper Hospital de Détroit. Deux années de recherche ont amené à des changements radicaux au programme d'étude et on a vu la nécessité d'appuyer davantage sur la surveillance et l'enseignement. L'instruction de base, permettant aux élèves de se présenter aux examens d'enregistrement, sera donnée durant 119 semaines. Le reste du cours portera sur les relations du personnel, la surveillance, et l'enseignement.

CHEZ LES NÔTRES

L'Association des Infirmières de la Province de Québec est heureuse d'annoncer que le programme d'étude à l'usage des écoles de langue française vient d'être terminé (1ère année). Les institutrices, sous la conduite éclairé de Soeur Rheault, directrice des études à l'Hôpital Notre-Dame, ont présenté un programme pratique, répondant aux besoins de notre temps. Il sera mis à l'essai durant un an dans nos écoles, puis reviser.

NOS MEILLEURS VOEUX

Le personnel du Secrétariat National souhaite à tous les membres de l'A.I.C. un Joyeux Noël et beaucoup de bonheur durant la Nouvelle Année.

Annual Meeting in Prince Edward Island

The 31st annual meeting of the Association of Nurses of Prince Edward Island was held on Wednesday, September 24, in Charlottetown.

As part of the program of the annual meeting, Miss Marjorie Russell, nursing consultant to the Department of Veterans Affairs, spoke to the members on "The Nursing Assistant and the Nursing Team." In order that as many members as possible might have the opportunity to participate in the program, meetings were held on September 22 and 23 at two centres. Miss Russell is well qualified to speak on the subject and her talks elicited a great deal of interest as shown by the range and amount of discussion which followed. Her coming was very timely as "An Act to Provide for the Training, Licensing and Practice of Nursing Auxiliary Personnel" was passed by the legislature of Prince Edward Island in the spring of 1952 and will presently go into effect.

The president, Sister Mary Stanislaus, presided at the meeting. In her presidential address she reviewed the advances made by the association since 1939 by drawing comparisons with 1952. The contrast in number of graduates, personnel of the Board of Examiners, legislation for nursing, service through nursing registries, and the physical set-up for provincial office showed the progressive changes through the past 13 years. She also reminded the members of the need of following through in Civil Defence training, so as to be prepared at any time to accept responsibilities should disaster occur.

The secretary-registrar described the activities during the past year of the Executive Committee. She spoke of the Core Committee chosen from the Executive that met to discuss the altering of the educational standards of applicants to schools of nursing in P.E.I. Due to pressure from certain groups this is a step the association is being forced to take. On recommendation to the Minister of Health and Welfare, a combined meeting of representatives from the fields of education, medicine, hospital, health and welfare services met with nursing representatives. As a result of discussion a resolution was formulated to be presented to the general meeting:

> WHEREAS, It is not the wish of this Association to open the Act if such can be avoided; and
>
> WHEREAS, This Association does not wish to lower the present standards of educational requirements for entrance to schools of nursing in Prince Edward Island; and
>
> WHEREAS, More flexibility in interpretation of the word "matriculation" is desirable; therefore be it
>
> *Resolved*, That the Nurses' Act, 1950, not be opened but that a committee of three educationalists be appointed to evaluate the educational credentials of prospective student nurses and that consideration be given to those where an equivalent of matriculation is indicated and that these students be accepted in our schools of nursing.

Other activities mentioned were:

The three-day *refresher course* in nursing held in November, 1951. The subjects included in this course were: Nursing in Psychiatry; Geriatrics and Cardiac Diseases; Laboratory Tests and Legal Aspects of Nursing.

The *report on Civil Defence*—Six nurses from P.E.I. attended a four-day instructors' course on "Nursing Aspects of A.B.C. Warfare." Since then four 12-hour courses have been given by the nurse instructors and co-lecturers.

The A.N.P.E.I. was appreciative of the invitation extended by the New Brunswick Association of Registered Nurses to a four-day *institute for instructors and head nurses* held in June. Seven nurses from P.E.I. took advantage of this opportunity.

The resolution regarding educational standards for applicants to schools of nursing was discussed at length, the concensus being agreement with the resolution, if equivalent would not be interpreted to mean less than matriculation.

Reports from the two districts, the standing and special committees were encouraging in that they showed progress in carrying out the functions of the association. Recommendations on personnel practices have been set up and some progress has been made in organizing the curriculum.

Delegates who attended the biennial meeting of the Canadian Nurses' Association at Quebec City brought to the meeting very complete and comprehensive reports that were heard with interest.

During the afternoon session, Miss Patricia Arsenault spoke on "Medical Records and the Medical Record Librarian." She covered the duties of the medical record librarian and the newest methods of keeping medical records. Her talk was interesting and informative, in that it concerned a part of record work not familiar to nurses.

Following the annual dinner, Dr. A. A. MacVicar, Assistant Director of Mental Health, chose as his topic "Psychiatric Problems in Nursing." The problems he discussed were those found in our day-to-day patients in general hospitals: the average man or woman whose outlook has been altered because the environment has changed.

The officers elected for the term 1952-53 are as follows:

President, Verna Darrach; first vice-president, Helen Schurman; second vice-president, Sister Mary Irene; honorary secretary, Hazel Adams; honorary treasurer, Ida MacKay.

MURIEL ARCHIBALD
Secretary-Registrar

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A few comments from prominent nurses (names on request):

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Elmwood, Ont.

In Memoriam

Helen (Cooke) Fisher, who graduated from the Royal Victoria Hospital, Montreal, in 1945, died in the United States following an attack of poliomyelitis in the summer of 1952.

* * *

Vivian (Powers) Landry, who graduated from the Royal Victoria Hospital, Montreal, in 1940, died suddenly in New Brunswick in September, 1952.

* * *

June (McPhail) Little, a graduate of the Moose Jaw General Hospital, Sask., died in Vancouver on September 21, 1951, at the age of 33. Prior to her final illness, Mrs. Little had been working on the staff in the Tuberculosis Unit of the Vancouver General Hospital.

* * *

Marguerite Gwendolyn Macara, who graduated from the Toronto General Hospital in 1924, died in Toronto on July 14, 1952. Miss Macara had been medical librarian at the Hospital for Sick Children.

Bridget McIver, who was the first graduate of the Misercordia Hospital School of Nursing, Winnipeg, after its establishment in 1916, died at Brandon, Man., on August 13, 1952, at the age of 70.

* * *

Margaret (McCallum) Meech, who graduated from the old Western Hospital in Montreal in 1924, died on August 15, 1952. Mrs. Meech had worked in the x-ray department of her own hospital for three years and on the staff of the Ottawa Civic Hospital for two years prior to her marriage in 1929.

* * *

Winnifred Moore, who graduated from St. Luke's General Hospital, Ottawa, died recently in Ottawa following a long illness. Miss Moore had served overseas during World War I.

* * *

Isabel Paisley died in St. Thomas, Ont., on September 30, 1952. In World War I,

"EXPORT"
CANADA'S FINEST
CIGARETTE

Miss Paisley served as an army nurse with the American Forces.

* * *

Josephine Belle Peters, who graduated from the Vancouver General Hospital, in 1916, died in Nanaimo, B.C., in September, 1952, at the age of 63. Miss Peters was one of the pioneers in British Columbia's fight against tuberculosis. Soon after graduation she joined the Rotary Club Tuberculosis Clinic where she worked until she joined the British Columbia Tuberculosis Society, working with the first travelling chest x-ray unit in the province. In 1937 she became supervisor of nursing in the Division of Tuberculosis Control of the provincial health department and served in that capacity until her retirement in 1948.

* * *

Annie Smith, who served in the Yukon during the gold rush days of 1898, died in Victoria on September 15, 1952. In 1905 Mrs. Smith moved to Vancouver where she engaged in institutional work for many years.

* * *

Marian Isabel (Cowdray) Walker, who graduated from Grace Hospital, Windsor, Ont., in 1947, died suddenly in Windsor on September 6, 1952. Prior to her marriage Mrs. Walker had been a member of the staff of the Victorian Order of Nurses in Walkerville, Ont.

WHO Publications

Nurses who are interested in reports of the World Health Organization may be interested to know that the following publications are obtainable from **The Ryerson Press, 299 Queen St. W., Toronto 2B, Ont.:**

Expert Committee on Health Statistics—Third Report	.35
Expert Committee on Environmental Sanitation—Second Report	.15
Expert Committee on Nursing—Second Report	.15
Expert Committee on Maternity Care—First Report	.15
Expert Committee on Insecticides—Third Report	.25
Official Records of The World Health Organization Executive Board	.25

Training of Personnel

In the implementation of a program of maternity care, expenditure for adequate training of personnel should take precedence over other expenditures if, in fact, a choice has to be made. The training program should cover all physical and mental aspects of maternity care. In relation to the latter aspects, the committee supports the views expressed by the Expert Committee on Mental Health at its second session that the basic principles underlying the mental hygiene training of all public health workers are to provide them with "an adequate knowledge of personality structure and development and aid them in understanding and modifying human behavior." In this committee's view "mental hygiene training should aim at giving the public health worker a broad understanding of human behavior and should not consist of a formal course in psychiatry." The second point is made that "such material as is presented will be more effective if it is integrated into the various established courses in the curriculum rather than given as a separate course."

—*WHO Expert Committee on Maternity Care*

Most of the nations outside of North America and Europe are sadly deficient in medical personnel due to the lack of modern medical schools in these regions. To be sure, in many of the countries one finds physicians of top quality but usually they are persons who obtained their professional training in Europe, the United States or Canada. Training abroad, however, is costly; fellowships can be provided only for the occasional brilliant student who shows unusual promise; and, moreover, the number of outside applicants for whom places can be found in American and European schools is narrowly limited. The only permanent solution of the problem is the development of first-class training centres within the countries themselves. It was recognition of this acute situation that led the Foundation to put *professional education* first in formulating its program in medicine and public health.—THE ROCKFELLER FOUNDATION.—*A Review for 1950 and 1951.*

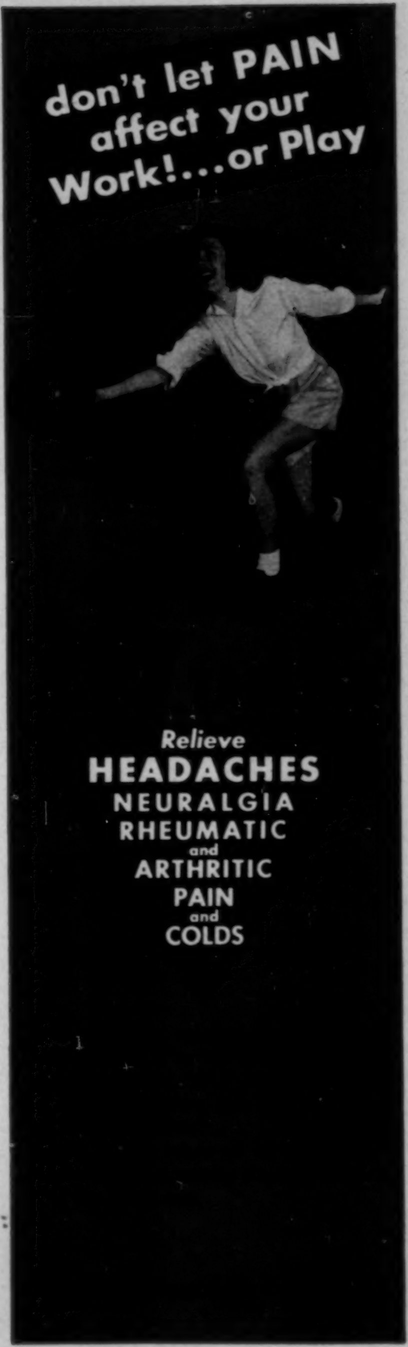
Book Reviews

A Textbook of Medical Conditions for Physiotherapists, by Joan E. Cash, B.A., M.C.S.P. 350 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 1951. Price $4.25.

Reviewed by Reta I. Clarke, Physiotherapist-in-Charge, Westminster Hospital, London.

Physiotherapy has so reecntly joined the medical team that there has been little information concerning medical conditions commonly treated by physiotherapy. In this textbook, Miss Cash, an English physiotherapist, has gathered together all existing material and presented it very simply under seven headings. Each medical condition is described and then followed by an outline of treatment by physical measures.

Part One is concerned with the pathological changes that take place. It tells how the various tissues break down, often as the result of disturbances in the circulation. Part Two is devoted to arthritis (rheumatoid, osteo, and muscular) and its crippling manner of attacking the joints and the surrounding tissues. Part Three describes a few of the respiratory disorders, both operative and non-operative.



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Part Four is a very long section discussing the many and varied disorders of the nervous system, including the hemiplegias, paraplegias, cerebral palsies, muscular atrophy, nerve lesions, and neuritis. Part Five describes diseases of the cardiovascular system—coronary thrombosis, arteriosclerosis, Raynaud's disease, phlebitis, varicose veins. Part Six mentions a few disorders of the abdominal viscera, such as tuberculous peritonitis, constipation, visceroptosis. Part Seven discusses the common diseases of the skin such as acne vulgaris, psoriasis, and alopecia.

This book would primarily be useful as a reference book for physiotherapists, both students and graduates, but should prove informative for anyone seeking to discover where and when physiotherapy might prove helpful in further treatment of a patient.

Interpersonal Relations in Nursing, by Hildegarde E. Peplau. 330 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1952. Price $5.25.

Reviewed by Irene Leckie, Nursing Arts Instructor, University of Alberta Hospital, Edmonton.

In the introduction the author states: "The purpose of this text is to aid graduate nurses and nursing students to improve their relations with patients. Many nurse practitioners wish to deepen their understanding of interpersonal relations in nursing situations in order that their work will be more effective and socially useful. . .It proposes concepts that may be learned and become incorporated into the functioning personality of every nurse who is willing to struggle toward greater maturity in her relations with others."

The text is divided into four parts with the purpose of each part and an overview presented. In each chapter, following the overview, essential questions are stated; these are discussed and the chapter concludes with a summary. At the end of the text a selected bibliography is listed and includes such topics as anxiety, illness as an event, learning and therapeutic methods, to name only a few. This is followed by a comprehensive index.

In Part I, in the discussion of What is Nursing? the author elaborates on the relationships established by the nurse, not only with the patient but with other workers in the hospital and in the community, in order that "physical, emotional and social well-being may develop as a learning and maturing process for the nurse and extend from the nurse to the patient." This part also includes a chapter on Roles in Nursing, emphasizing how the nurse meets the needs of the patient when she first meets him as a stranger, how she can interpret the nursing and therapeutic procedures to him, her role as a teacher, and a discussion of the phases and changing roles in nurse-patient relationships. The way in which the patient reacts to the nurse in her various roles is well explained in this chapter.

The second part deals with the kinds of basic human needs which seek expression in the nursing situation and includes clinical experiences. One case is of a nine-year-old child, the other a young adult and are considered under the headings of Steps in Learning Experience and Behavior Observed. This is followed by some generalization on the summary of needs expressed in the two cases. There is also some discussion of goals, frustration, conflict, which brings out the fact that the nursing should be based upon psychological principles.

The next part discusses feelings of dependence as a recurring problem in nursing and how they can be met. For example, in the chapter Learning to Delay Satisfaction the summary concludes with the sentence: "Nurses who aid the patients to feel safe and secure, so that wants can be expressed and satisfaction eventually achieved, also help them to strengthen power that is needed for productive social activities." This leads to a discussion in the rest of the chapters of the mental picture the individual has of himself and how it operates when he relates to other individuals. The social and environmental factors which bring this into being are outlined, showing how the nurse's preconceptions can influence her relationships with the patient.

Observation, communication, and recording, specifically as a means of studying interpersonal relationships as they develop in the nurse's contact with patients, are explained in Part IV.

Throughout, the author shows how "the nurse can aid in making current human relations significant in terms of growth" for both herself and the patient. With the present-day emphasis on teaching of attitudes and a recognition of the importance of the establishment of good interpersonal relationships, the text has many suggestions which could be used to advantage by teachers in all phases of nursing. The book is thought-provoking and, while it is suggested that it is also for students, the terminology, in parts, would be too technical for one without some background in psychology.

News Notes

ALBERTA

CALGARY

Thirty members were present at the annual meeting of District 3 when correspondence was read dealing with the delegate's expenses to the provincial annual meeting. It was moved that a Convention Fund be established with a definite method of collection.

The following reports were presented: President, M. Murray; treasurer, M. Watt; private duty section, M. Newborn; public health committee, P. Harley; instructors' group, M. McKay; labor relations committee, F. Tennant; Christmas parcels committee, J. Shaw; nominating committee, Mrs. M. Duthie; civil defence committee, M. Deane-Freeman; Council of Social Agencies, Mrs. C. White.

The district was requested to send representatives to the Alberta Hospital Association convention.

The following officers will serve for the coming months: President, F. Tennant; vice-president; J. Shaw; secretary, L. Bibby; treasurer, Mrs. E. Jones.

JASPER

A meeting of Edith Cavell Chapter was held at the home of Mrs. Nordgren with 11

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Director of Nursing
General Hospital
Vancouver 9, B.C.

members present. Mrs. C. Van Dusen, A.A.R.N. registrar, was guest speaker. The secretary, Mrs. R. Recknagle, and the treasurer, Mrs. Bonner, were requested to attend a luncheon for the Governor General. Informal discussion followed on various subjects: new personnel policies for nurses and nurses' aides; difficulties with foreign-trained nurses; insight as to what we might hope for at the annual meeting next May; and the possibility of obtaining guest speakers for the regular chapter meetings.

Mr. A. Holland of Abbott Laboratories Ltd. gave an informative talk on new drugs, including the new treatment for epilepsy.

WESTLOCK

Mrs. F. Roberts, the president, was in the chair at a meeting of Westlock Chapter. She was a delegate from Alberta to the C.N.A. convention in Quebec City and presented her report on developments at the meeting. The members made plans for a telephone bridge and for Christmas parcels to be sent to all student nurses from the Westlock school district. The executive committee will meet to decide on the scholarship to be awarded to a student nurse from the Westlock area. Two chapter members have left this district—H. Wager and B. Presho. Lunch was served by Mmes K. Spragge and B. Gray.

BRITISH COLUMBIA

EDGEWOOD

M. E. Molloy, who has been matron of the Red Cross Outpost Hospital here, is going to Nakusp to take over similar duties at Arrow Lakes Hospital. She will be succeeded by Mrs. Hazel Walsh, who comes from New Zealand and has been in the province for the last two years. During that time she has specialized in private nursing, mostly at St. Paul's Hospital, Vancouver.

LADYSMITH

Mrs. J. W. Neville was re-elected president of Ladysmith Chapter at the recent annual meeting. Other officers are: Secretary, Mrs. P. Gannon; treasurer, Mrs. C. Bredenberg; social convener, Mrs. E. F. N. Robinson. M. McStay and E. Jarvie, two nurses from Scotland now on the local hospital staff, were welcomed. An electric iron and ironing board will be purchased for the nurses' home. It was proposed that the local chapter invite the members of Chemainus Chapter to a joint meeting here when defence films will be shown.

PRINCE GEORGE

The vice-president, S. Bradford, was named to carry on presidential duties for the Fort George Chapter, following president M. McKinlay's transfer to Chilliwack, at the first fall meeting. T. Fagan was in charge of the refresher course in connection with A.B.C. warfare nursing. D. Munro's account of the C.N.A. biennial convention was a highlight of the meeting.

TRAIL

At a regular meeting of Trail Chapter plans were discussed for a rummage sale and a sale of home-baking. E. Sproule, delegate to the C.N.A. biennial convention in Quebec City, gave an excellent report.

VANCOUVER

Five general and five executive meetings have been held by the Vancouver Chapter since the annual meeting and the president, Edna Rossiter, gave the following report at the Greater Vancouver District meeting in October:

Five delegates were sent to the provincial annual meeting in Victoria in May and the president served as delegate to the C.N.A. biennial convention in Quebec City.

A scholarship of $250 was forwarded to the University of British Columbia for the leading student in the teaching and supervision course. This was awarded to Vivian Jackson and is known as the Vancouver Registered Nurses' Award. F. Fleming received the $250 bursary loan for study in administration.

The Private Duty Nursing Committee organized a supper meeting in March when M. Trowbridge spoke on "Nursing Care in Thoracic Surgery." Twenty-three private duty nurses have since attended clinics on this subject given by Miss Trowbridge at Shaughnessy Chest Unit.

Interesting programs have been arranged including: "The Organization of the School of Nursing at U.B.C." by Evelyn Mallory; the film "Royal Tour" taken by B.C. Electric Co.; the film "Breakdown," introduced by Miss Mitchell, instructor with the Provincial Health Services, Essondale; reports of the C.N.A. biennial, by B. Whittaker, president, Student Nurses' Association of B.C., and Miss Rossiter.

T. Hunter was appointed to the Health Committee for the British Empire Games.

St. Paul's Hospital

Sr. Dennis Margaret has recently received her M.A. of Nursing Education from Washington, D.C. E. (Howell) MacKenzie is now on staff of 4.5. M. Johnson is on duty with the pediatric department, Vancouver General Hospital. H. Clegg has resumed her post at Crouse Irving Hospital, Syracuse, N.Y., after a trip to England. W. Taylor, nursing arts instructor at a private hospital in Beverley, Mass., was a recent visitor. D. (Beaubien) Bean, M. (Borstal) Pozer, and B. (Elliot) Pollack are living in Kelowna.

WILLIAMS LAKE

The Williams Lake Area Chapter was formed on September 15, 1952, at a meeting held at the War Memorial Hospital. Mrs. M. Johnstone was named president of the new group with A. Wiens as vice-president. The secretary-treasurer is Mrs. J. Routledge with Y. Parliament serving as program and social convener. Ten active and non-active nurses were in attendance. There is a potential membership of 25 in the area.

MANITOBA

WINNIPEG

General Hospital

Mrs. J. E. Wilson, the president, was in

THE ART AND SCIENCE OF NURSING

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NURSING-ARTS GUIDE

By Ruth Rhodes Joseph, R.N., B.S., Brackenridge Hospital School of Nursing, Austin, Texas. An integrated course, arranged in the unit system. In constant use for eight years, and revised annually, the material has proved successful in widely divergent types of schools. 94 pages, spiral binding, 1951. $2.50.

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● Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver 1,* to be completed & returned to the

Chairman, Victoria.

charge at a meeting of the alumnae association when it was announced that L. Lethbridge has taken the post of corresponding secretary, replacing A. Robertson who has been called from the city. Miss Lethbridge is on the staff of the M.A.R.N. Mrs. W. H. Anderson, program convener, outlined the social events for the season, which include an auction sale, Christmas carol-singing, and the annual tea. At the close of the meeting Mrs. C. Dojack, past president, presented B. Pullen, superintendent of nurses, with a silver coffee urn for the nurses' home. Space has been provided for a cobalt bomb in the x-ray therapy department.

D. Hibbert, assistant superintendent of nurses, is at Columbia University working towards her degree in administration. I. Cooper, clinical instructor in obstetrics, is also at Columbia, specializing in obstetrical nursing. B. Seeman, nursing arts instructor, is taking teaching and supervision at McGill School for Graduate Nurses. S. Tretiak is filling Miss Seeman's position. A. Aikman, having obtained her certificate in administration in schools of nursing from McGill, is at present serving as assistant to the superintendent of nurses. R. Kelsall, a graduate of the Toronto General Hospital, is serving on the W.G.H. staff. E. M. Foley, a graduate of St. Joseph's Hospital, North Bay, Ont., is science instructor.

NEW BRUNSWICK

MONCTON

Mrs. Colwell, chairman of Moncton Chapter, presided at a regular meeting when plans were finalized for the Food and Fancywork Sale. F. Breau, superintendent of nurses at Moncton Hospital, gave an account of the C.N.A. biennial convention in Quebec City. Mrs. M. Perry reported on the Registry Board, announcing the appointment of Mrs. E. Stone as registrar due to the resignation of Mrs. Buchanan.

ST. STEPHEN

Eleven members were present at a meeting of St. Stephen Chapter when M. McMullen was in the chair in the absence of the president. After some discussion regarding registration of nurses and the local registry, it was made clear that nurses who applied for duty in the hospital must first be interviewed by a staff member before their names could be placed on the registry. Letters of thanks and appreciation were read from Rev. Mr. Rogers and H. Bartsch. Miss Parsons, one of the four delegates who attended the annual meeting of the Children's Aid Society in St. Andrews, gave her report. Mrs. McGarrity was appointed delegate to the N.B.A.R.N. annual meeting in Saint John.

A committee was appointed to take charge of the chapter's annual meeting when a banquet will be held. This consisted of: Misses Parsons, McMullen, Mmes Beek, Trainor, Bartlett. Miss Lyons and Mrs. Parks were named as nominating committee to present a slate of officers at this meeting.

Following adjournment, the nurses enjoyed a corn boil, the corn being supplied from Dr.

Burton's garden. Hostesses for the evening were: M. Brownrigg, G. Vail, J. Dugan, and Mrs. T. Young.

NEWFOUNDLAND

ST. JOHN'S

Afternoon tea was served recently at the General Hospital by the preliminary student nurses in honor of Margaret E. Kerr, of Montreal, editor and business manager of *The Canadian Nurse*. Miss Kerr was in the city in the interests of the *Journal* and planned to visit Corner Brook. Once a month the preclinical students entertain at tea in the nurses' residence. This is a special feature of their training as beginners and each month an honored guest is invited.

NOVA SCOTIA

NEW GLASGOW

Aberdeen Hospital

Mrs. C. Cooke was in the chair at a meeting of the alumnae association when routine reports of the committees were heard. The treasurer's statement by J. MacLaughlin proved encouraging and plans for the future were discussed. Refreshments were served by M. Ross, B. Weatherby, and Mrs. Cooke.

ONTARIO

DISTRICT 1

STRATHROY

About 90 nurses gathered at the fall meeting of the district when Canon H. B. Ashby gave the invocation and a welcome was extended by Mayor T. Fred Paul. Edith Horton, district chairman, was in charge of the program. Mrs. B. Mason, Strathroy Hospital superintendent, was appointed resolutions committee chairman.

Miss Horton said that three of the five counties of the district had either formed or were forming chapters of the R.N.A.O. as part of the district organization. For that reason she favored lowering the number of meetings of the district to two per year.

Interest committee reports were given by: M. I. Graham, the secretary-treasurer, on institutional nursing; P. Thomson, public health nursing; Mrs. F. Clazie, private nursing; M. Sloan, industrial nursing. All reports stressed that most nurses were taking the A.B.C. warfare nursing course. B. Meagher, Strathroy Hospital, contributed two solos, and Mrs. O. L. Graham gave a demonstration on flower arrangements for the sick room.

Edith Fenton, R.N.A.O. public relations secretary, was the guest speaker at the evening banquet.

CHATHAM

Mrs. G. Berry of Merlin will head the newly organized Kent Chapter. In attendance at the organizational meeting were the district president, E. Horton, the district secretary-treasurer, M. Graham, and M. Stewart. The meeting, chaired by Mrs. M. Harrison, a past district president, was attended by 60 graduate nurses from Chatham and district. Additional

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For further information write to:

Supt. of Nurses,
General Hospital,
Winnipeg, Man.

members of the executive include: Vice-presidents, D. Stevens, M. Gilbert; secretary, Mrs. D. Chambers; treasurer, D. Marini; city and program chairman, Mrs. M. Harrison.

WINDSOR

Grace Hospital

From a Yukon frontier log cabin to superintendent of a modern city hospital is the proud record of newly promoted Brigadier Doris M. Barr, head of the Salvation Army Grace Hospital. Graduating from Grace Hospital, Brigadier Barr served for nine years with the Army in Halifax, Ottawa, Winnipeg and Korea. She was named director of nursing of the Windsor hospital in 1934 and served 15 years in that post until her appointment as hospital superintendent three years ago.

The rank of brigadier is the highest generally attained by women in the Army with the exception of national officers. It is in recognition of long and valuable leadership both of which qualifications Brigadier Barr fulfilled over a long period.

DISTRICT 2

INGERSOLL

The opening meeting of the season of the nurses from Ingersoll and district was held at Alexandra Hospital with the president, Mrs. C. Pittock, in charge. The secretary, Mrs. F. Newman, read her report and also that of the treasurer, in the absence of Mrs. T. Morrison. Plans were made for a series of lectures on A.B.C. warfare, to be given by Mrs. M. Kilcupp of Sarnia. An interesting feature of the meeting was the showing by R. Grieve of beautifully colored slides of her trip to Great Britain and the Continent. Mrs. J. Meatherall and her committee served refreshments.

DISTRICT 3

GUELPH

General Hospital

The following changes have occurred in the executive for the alumnae association: Secretary and social convener, Mrs. G. M. Elliott; *Blue Cross* secretary, F. Mortimer.

A successful tea and penny sale was held last spring. Mrs. Kate Aitken was guest speaker at the annual alumnae dinner held in honor of the 13 members of the 1952 class of the School of Nursing. By a roll call, it was found that 35 classes of past years were represented. In June, the annual picnic was well attended and, at the September meeting, reports of the C.N.A. convention were heard in dialogue form by E. Lamont and E. Raithby. A card party was held in October and a dance in November.

DISTRICT 4

DUNNVILLE

Mrs. Florence Bennett has resigned as superintendent of the Haldimand War Memorial Hospital.

NIAGARA FALLS

The following officers comprise the executive for the Greater Niagara Hospital Alumnae Association: President, M. Grieves; vice-presidents, Miss I. Betts, Mrs. K. Lockyer; secretary, Mrs. M. Crawford; treasurer, Mrs. J. White; social convener, Mrs. P. Evans; visiting, Mrs. N. Scott.

DISTRICT 5

TORONTO

The members of District 5 held a general meeting at the Hospital for Sick Children, when Kay Barry, senior student at the hospital, gave a lively account of the student activities at the C.N.A. biennial convention. Laura Fair described the social activities for the graduates and summarized the Lord Report on the Metropolitan School of Nursing in Windsor. Miss Hendrikz, district chairman, gave an account of the studies undertaken by the C.N.A.—the Jewett Structure Study and the Head Nurse Activity Study.

A film "Turkey—Key to the Middle East"—was shown, followed by a discussion on the woman's point of view in that country, given by Muzzez Karamen, a Turkish post-graduate nurse who is attending the University of Toronto School of Nursing.

DISTRICT 6

PORT HOPE

Mr. A. H. Humble of Trinity College School gave a stimulating address on "Education for Democracy" at the annual meeting of the district. A most enjoyable dinner was served by the ladies of Pine St. United Church while Miss Kellough led a singsong. The election of officers took place later.

DISTRICT 7

SMITHS FALLS

Mrs. Doris Carson, a member of the Public Hospital staff for the past four years, has been named acting superintendent following the resignation of Evelyn Wood. Miss Wood has taken over the post of superintendent of Ross Memorial Hospital, Lindsay. Mrs. Carson has been night supervisor at the Public Hospital, her former duties now being carried out by Mrs. Rita Shaw.

Prior to her departure, Miss Wood was honored at many receptions. She was presented with a gift by Mrs. D. Cameron, on behalf of the local Business and Professional Women's Club, and received a purse from the hospital staff, presented to her by Mrs. W. Beckett.

DISTRICT 8

OTTAWA

The Board of Directors of the Community Nursing Registry agreed at a recent meeting to become a member unit of the Welfare Group of Ottawa and the local Council of Women. E. Horsey was in the chair. During the brief business session, L. Gourlay, finance committee chairman and a member of the credentials committee, reported that the organization had shown a substantial surplus. Pearl Stiver, representative of the city health nurses, was congratulated by the Board on her appointment as C.N.A. general secretary. I. Johnston presented the treasurer's report in cooperation with Miss Gourlay.

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Grace Hospital

Mrs. C. Bradwin was in the chair at a meeting of the alumnae association held at the home of Mrs. G. Radbourne. Plans for future activities, including the annual bazaar, were discussed and reports from conveners received. Refreshments were served by the hostess, assisted by Mrs. J. R. Webster.

St. Luke's Nurses' Alumnae

The alumnae held their annual tea in October when the guests were received by the president, Mrs. G. Gamble, and by G. Woods. Those wso assisted in pouring tea included: M. Stewart, V. Adair, E. Gordon, E. L. Smellie, A. Macleod, I. Johnston, E. MacIlraith, Mmes J. A. Steele, C. Humphreys, and D. Kipp. Proceeds went towards charitable donations.

DISTRICT 11

ORILLIA

E. Pittuck was chairman of the first meeting of Chapter 3 held at the Ontario Hospital. Twenty-one members were present. Laura Fair, nursing supervisor, Ontario Department of Health, gave an informative address on "The Nursing Aspects of A.B.C. Warfare," outlining the instructors' course which was given in Toronto. Three nurses from the chapter having attended this course, they will be prepared to give a 12-hour course to registered nurses throughout the community. Dr. Augusta Mae, of the Ontario Hospital staff, gave an enlightening talk on life in Estonia, followed by motion pictures of Sweden, Norway, and England.

DISTRICT 12

On May 3, 1952, a baby was born in Ontario—a lusty, sturdy baby, so full of energy that it just couldn't be kept down, and so, in true northern fashion, this baby developed at such an alarming rate that four months later, on October 18, it made its debut.

Yes, District 12 came out, and came out with a bang in Cochrane where 77 registered nurses gathered from far scattered areas throughout the district in an enthusiastic rally. From Moose Factory and Hearst, from Kapuskasing and Timmins, and so on down the line to Cobalt, interested nurses left their large and small towns and headed for Cochrane. Some travelled over 200 miles—two guests from District 9 came from North Bay, a distance of 262 miles, just to get together at our coming-out party.

Eighty-one guests, including the mayor of Cochrane, three members of the Medical Society, and two student nurses from Timmins sat down to a sumptuous turkey dinner. Doris Dooley, public health nurse for the town of Cochrane, and her committee are to be congratulated on the splendid arrangements—not a thing was left out.

Over coffee and cigarettes a formal welcome to Cochrane was extended by Mayor Palangio. Betty Houston, chairman of District 12, expressed her appreciation of the wonderful turnout and spoke a few words on "Interested People." Briefly she explained the nursing set-up of Ontario in general and of District 12 in particular. She emphasized the fact that without members there will be a lack of money, and there must be money to carry on a program of organization and development in this vast northern region. The responsibility, she said, lies with the individual nurse, so each one must make a genuine effort to get members. Then, when the district is well informed, interest is sure to follow.

Miss Houston then introduced the beloved R.N.A.O. president, Miss Gladys Sharpe, who made a special trip from Toronto to be guest speaker. She gave an inspiring talk on "Citizens of the World." Her description of the structure of nursing, its responsibility to the world, and the individual responsibility of nurses to the nursing profession as a whole, brought out the thought that nursing is not an individual career but a corporate profession and must be worked through as such.

District 12 is a large area and so far has comparatively few members (120 with a potentiality of 300-400) but they are united with one aim in view—the betterment of the nursing profession.

QUEBEC

MONTREAL

General Hospital

Jean Dayman was honored at a tea held in October at the Western Division. A member of the staff for several years, she was presented with a travelling clock. Miss Dayman will be taking up her duties in Lindsay, Ont., her home town.

Royal Victoria Hospital

Seventy-five preliminary students were welcomed to the School of Nursing in September.

At the first general meeting of the alumnae association, the president, Mrs. C. Sutherland, reported that F. Munroe had accepted the chairmanship of the out-of-town alumnae chapters. Mr. R. W. Sparks, the guest speaker for the evening, outlined the work of the Speech Therapy Clinic now open at the hospital.

Alma (Sicard) Foulkes has been appointed director of nursing, Cohama County Hospital, Clarksdale, Miss. Word has been received from Ruth Wardell who is a medical missionary among the Mam Indians in Guatemala.

Back at McGill School for Graduate Nurses for post-graduate courses are: M. Dolphin, E. Johnson, O. Lowten, N. Pearson, M. G. Purcell, D. Stacey, N. Stratford, J. Thornber.

Recent visitors to the School included: B. Harding, returned from Great Britain; L. E. Lockeberg, who will resume public health duties at Deep River; C. (MacLeod) Young.

SASKATCHEWAN

SASKATOON

St. Paul's Hospital

Due to the devotion of nurses from the public health department and the alumni, polio patients are receiving the help they so badly need. Members of the faculty were able to attend the Catholic Hospital Convention and the provincial hospital meeting held in Saskatoon. R. Bienvenue (3A) was guest speaker at the October alumnae meeting, reporting on the C.N.A. biennial convention. Mary G. Walsh from Vancouver, of the 1923 class, visited the School recently. Rev. Walter Bédard of Regina conducted the annual retreat for student nurses.

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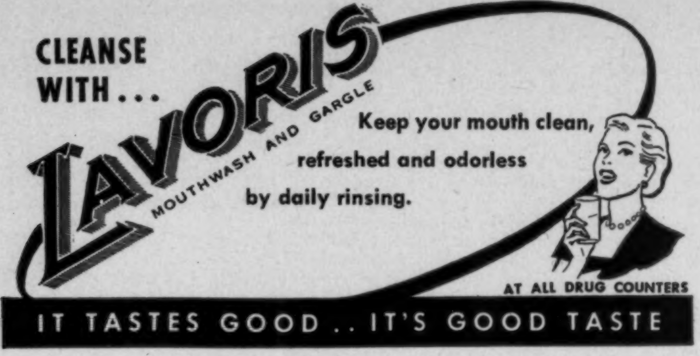
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Operating Room Nurses for Victoria General Hospital, Halifax, N.S. For details apply Director of Nurses.

Head Nurse—Surgical Floor & Medical Floor. Experienced. Beginning salary: $13.50 day; $14.50 afternoon & night. Desirable personnel policies. Hospital 20 miles from Detroit, 3 miles from Selfridge Air Force Base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

Office Nurse for Dental Surgeon's office at Levelland, Texas, U.S.A. Salary: $250-300 depending on qualifications. Any interested R.N. could easily learn duties. Apply Dr. B. J. Roberson, Box 1187, Levelland, Texas.

Registered Nurses for General Duty for Huntingdon County Hospital. This is a small General Hospital, in Town of Huntingdon, 45 miles southwest of Montreal, connected by excellent train & bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, badminton club, skating, curling, dancing & only 8 miles from summer resort on Lake St. Francis. Salary: $140 per mo. with full maintenance with 3 increases of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. & 4 wks. holiday. Apply Mrs. B. Grant, Matron, County Hospital, Huntingdon, Que.

General Duty Nurses for 100-bed hospital. Hours, salary & holidays according to R.N.A.B.C. recommendations. Contract pending. Complete maintenance—$47.50 if desired. Apply Supt. of Nurses, Kootenay Lake General Hospital, Nelson, B.C.

General Duty Nurses for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

General Duty Nurses—rotating periods. Salary: $180 per mo. plus Cost of Living Bonus. Laundry supplied. Additional $20 per mo. for evening or night duty. Annual increment—$120 for 3 yrs. 44-hr. wk. 8 statutory holidays. Vacation, 21 days & sick leave, 14 days with salary after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Dietitian for modern 82-bed hospital. No training school. Salary: $250-280 per mo. Apply, stating qualifications & experience, Supt., Union Hospital, Canora, Sask.

Supt. of Nurses for fully modern 82-bed hospital. No training school. Salary: $285-320 per mo. Apply, enclosing references & stating qualifications & experience, Supt., Union Hospital, Canora, Sask.

Head Nurse for 30-bed Pediatric Unit in 100-bed Children's Hospital. All-graduate staff. Experience in charge work as well as pediatric knowledge essential. R.N.A.B.C. recommendations. For further information apply Director of Nursing, Children's Hospital, 250 W. 59th Ave., Vancouver 15, B.C.

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Director of Nursing, The Montreal General Hospital,
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University of Alberta Hospital invites applications for **General Staff Duty.** Salary: Minimum $202 & maximum $230 per mo. 44-hr. wk. 3 wks. vacation annually. 11 statutory holidays. Cumulative sick leave. Pension plan & group insurance. Blue Cross. Consideration given to request for service in following depts: General medicine, medical specialties, general surgery, surgical specialties, pediatrics, obstetrics, operating room. Cost of railway ticket to Edmonton refunded after 1 yr. continuous service. Apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst Ont.

Hospital Supt.—Registered Nurse with hospital administration experience for 50-bed hospital with Training School. Full maintenance, vacation with pay & sick leave. Apply Chairman, Board of Trustees, Carleton Memorial Hospital, Woodstock, N.B.

Educational Director, Night Supervisor, General Staff Nurses for Maternity & General Wards. School of Nursing, approx. 200 students. Salary in accordance with position & qualifications as recommended by Sask. Reg. Nurses' Ass'n. For further details regarding positions apply Director of Nursing, City Hospital, Saskatoon, Sask.

Asst. Director of Nurses, Clinical Instructor & General Duty Nurses. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Instructor (qualified) to begin duties July 1, 1953. Salary: $240 gross. **General Staff Nurses** for medical, surgical & obstetrical floors. Salary: $180-195. gross depending on experience. 44-hr. wk. 2½ days holidays per mo. Half day on statutory holidays. 1½ sick days per mo. cumulative to 30 days. $30 charge for board & room. 177-bed hospital with Training School. Apply Mrs. M. Alexander, Acting Director of Nurses, General Hospital, Medicine Hat, Alta.

Matron (1) & Nurse (1) for Union Hospital, Lucky Lake, Sask. Salaries: $200 & $175 plus maintenance, respectively. Apply G. D. Clark, Sec.- Treas., Lucky Lake, Sask.

Junior Instructor (qualified) immediately to teach Nursing Arts. One class of students per yr. Salary: $215 increasing to $235. Room in residence available at $10 per mo. if desired. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

Obstetrical Supervisor & Staff Nurses for Archer Memorial Hospital, Lamont, Alta. Salary—prevailing schedule. Cost of Living Bonus. 5% increase bi-yearly. 1 mo. holiday at end of each yr.'s service. 8-hr. day, 1½ days off ea. wk. 1 long week-end ea. mo. Time allowed for all statutory holidays. Apply Supt. of Nurses.

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Applications should be accompanied by letter of acceptance of registration in B.C. from ***Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.***

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Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Operating Room Nurse for 36-bed hospital. Experience not essential. Salary: $165 with half yearly increments. Full maintenance. 8-hr. day, 44-hr. wk. 1 mo. holidays plus statutory holidays. Sick pay, 14 days per yr. cumulative to 3 yrs. Apply Miss C. Albers, Matron, Municipal Hospital, Brooks, Alta.

Dietitian for 50-bed hospital with extension opening first of 1953. Apply, stating qualifications, salary expected, etc., Supt., The Cottage Hospital, Pembroke, Ont.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

Graduate Nurses for General Operating Room & Ward Duty in 125-bed hospital. Straight 8-hr. day. 44-hr. wk. For further information apply Supt. of Nurses, Children's Hospital, Winnipeg, Man.

General Duty Nurses for large General Hospital. Openings available in all depts., including pediatrics & isolation, for nurses interested in permanent positions. Apply Director of Nursing, Victoria Hospital, London, Ont.

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General Duty Graduate Nurses for 60-bed General Hospital, situated 150 miles northeast of Vancouver on B.C. coast. Salary $222 per mo. less $25 for complete maintenance & laundering of uniforms. 4 wks. holiday with pay plus 10 statutory holidys. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

Graduate Nurses for 175-bed Tuberculosis Sanatorium near Prince Rupert. Salary for General Duty, $232 per mo. plus yearly increases. Room, board, laundry at $30 per mo. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

General Duty Nurses (3). Commencing salary: $220; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

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General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for modern 50-bed hospital. Gross salary: $215 less $40 board & lodging. $10 annual increase. 10 statutory holidays. 4 wks. annual vacation. 1½ days sick leave per mo. cumulating to 36 days. Transportation allowance not exceeding $60 refunded after 1st. yr. Apply Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

General Staff Nurses for 300-bed hospital—medical, surgical & pediatric services. Salaries: $1,620-1,920. Additional $10 per mo. for evening or night duty. Full maintenance provided. Attractive new nurses' residence. For further information apply Director of Nursing, Tuberculosis Hospital, East Saint John, N.B.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Nurses (2). Salary: $180 per mo. with full maintenance. Modern nurses' home. Usual holidays with pay, sick leave, etc. Transportation one way refunded if stay 1 yr. Apply Matron, Unions Hospital, Vanguard, Sask.

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Registered Nurses with Public Health training & experience, preferably generalized. Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 92 College St., Toronto 2, Ont.

Registered Nurses for General Duty for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts, 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Graduate Nurses for modern, well equipped Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr., 5-day wk. Liberal vacation. Holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

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Clinical Instructor. Salary determined by qualifications. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

Registered Nurses for St. Joseph Hospital, Mt. Clemens, Michigan, 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. **Staff Nurses:** $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

Graduate Nurses for Floor Duty in modern 50-bed General Hospital. Also **Operating Room Scrub Nurse.** Apply Supt., District Memorial Hospital, Leamington, Ont.

Registered Nurses for 74-bed General Hospital. 44-hr. wk. Rotating shifts. 1 mo. vacation per yr. Gross salary: $200 plus laundering of uniforms. $5.00 increases after 3 mos., 9 mos., 21 mos. later. Residence accommodation available at hospital—$15 per mo. Meals available at hospital—30 cts. per meal. Apply by phone or letter Supt. of Nurses, General Hospital, Portage la Prairie, Man.

Lady Supt. for 79-bed General Hospital, Kenora, Ont. Written applications, stating experience, age & references, to be sent to the Sec.

Matron for 18-bed hospital, midway between Calgary & Edmonton. Salary: $180 plus full maintenance. Also **General Duty Nurse.** Salary: $150 plus full maintenance. 1 mo. vacation with pay after 1 yr. 2 wks. sick leave paid for if not used. $5.00 per mo. increase after 6 mos. service to maximum of 3 increases. Transportation refunded after 6 mos. service. Apply Sec.-Treas., Municipal Hospital, Elnora, Alta.

Matron for 18-bed hospital. Salary: $250 less $45 maintenance in separate nurses' home. Beautiful Southern B.C. fruit valley—mild climate. New modern 30-bed hospital under construction. 1 mo. holiday, sick leave, etc. Apply Sec., Creston Valley Hospital, Box 30, Creston, B.C.

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Public Health Nurse for General Program in urban centre of 27,000. Minimum salary: $2,400 per annum. 5-day wk.: 8:45 a.m.-5:00 p.m. Lunch 1¼ hr. Employment benefits include: Pension plan, sick leave, 3 wks. vacation. Apply Mr. Norman T. Dawe, Personnel Officer, Westmount City Hall, 4333 Sherbrooke St. W., Montreal 6, Que.

Registered Nurses for major Surgical Wards in well equipped 280-bed Manitoba Sanatorium at Ninette, Man. Starting salary: $195 per mo. rising to $215 per mo. Annual increments. Well furnished & comfortable rooms. Generous vacations with pay. 11 statutory holidays. Group insurance. Contributory retirement plan if desired. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

General Staff Nurses (2) for day duty only in 75-bed Children's Hospital in suburban Toronto. Live in or out. 44-hr. wk. Salary range: $190-210 gross. Apply Director of Nursing, Hospital for Sick Children, 555 University Ave., Toronto 2, Ont.

Supt. of Nurses for 50-bed hospital. Must be well qualified person. Salary open. Apply, stating qualifications, experience & reference, Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

Science & Nursing Arts Instructors (one of each). New hospital to open early in 1953. Salary open. Apply Supt., Charlotte County Hospital, St. Stephen, N.B.

Registered Nurses for 34-bed General Hospital. Salary: $165 per mo. for 1st yr., $175 for following yrs.; $30 per mo. extra for night duty. Full maintenance, 3 wks. vacation with pay for 1st year., 4 wks. after 2 yrs. service. 12 days sick leave a yr., cumulative to 30 days. All statutory holidays. Travel expenses paid within Province of Manitoba for personal interview. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Registered Nurses for General Duty in busy 70-bed General Hospital. Commencing salary: $180 per mo. for 44-hr. wk. Good personnel policy. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

ADDITIONAL "POSITIONS VACANT" FOUND ON PAGE 1032

Official Directory

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

Pres., Mlle A. Martineau, 671 ave Ogilvy, Montréal 15; Vice-Pres. (*Eng.*), Sr. M. Felicitas, Miss H. Lamont; (*Fr.*), Sr. St. Ferdinand, Mlle G. Charbonneau; Hon. Sec., Miss M. Wheeler; Hon. Treas., Mlle E. Merleau; *Councillors*, Mlles M. Bissonnet (*Dist. 4*), A. Mailloux (7), M. A. Trudel (*8*), J. Gagnon (*9*), Mme M. Boisvert (*6*). The above constitute the *Executive Council* and are *Members of the Committee of Management*, together with: Mlles C. Julien, C. Samson, F. St. Pierre, L. Couet, M. Olivier, Misses V. Graham, K. Brady, C. Aitkenhead, Srs. Marie-Paul, Ste. Louise de Marillac, Marcil, J. Forest. *Advisory Com.*, Misses G. M. Hall, M. S. Mathewson, E. C. Flanagan, C. V. Barrett, Mlles R. Aubin, G. Lamarre, M. Lacombe, F. Verret, Sr. Valérie de la Sagesse, Mrs. J. Green. *Com. Chairmen: Institutional Nursing* (*Eng.*), Miss R. Francis, Western Div., Gen. Hosp., Montreal 25; (*Fr.*), Sr. Denise Lefebvre, Institut Marguerite d'Youville, Mtl 25; *Public Health* (*Eng.*), Miss A. Gage, 894 Osborne Ave., Verdun, Mtl 19; (*Fr.*), Mlle E. Merleau, Can. Red Cross, 3416 rue McTavish, Mtl 2; *Private Nursing* (*Eng.*), Miss R. Wood, 689 Rielle Ave., Verdun, Mtl 19; (*Fr.*), To be appointed. *Chairmen, Board of Examiners:* (*Eng.*), Miss A. Haggart, Royal Victoria Hosp., Mtl 2; (*Fr.*), Mlle J. Trudel, Hôp. Ste. Justine, Mtl 10. **Sec.-Registrar, Miss Winonah Lindsay. Visitor to French Schools of Nursing, Mlle Suzanne Giroux. *Association Headquarters, Suite 504-6, 1538 Sherbrooke St. W., Montreal 25.***

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Saskatchewan Registered Nurses' Association (Incorporated 1917)

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A.A., Public General Hospital, Chatham

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A.A., St. Joseph's Hospital, Guelph

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A.A., Ontario Hospital, Hamilton

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A.A., St. Joseph's Hospital, Hamilton

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